Administrative Control of Medical Quality
Day Hospital for Psychiatric Patients
Two Sides to the Question of Nurse Education

September
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1947

the Modern Hospital

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This Month

WE INTRODUCE....

D. Ewen Cameron, M.D., is professor of psychiatry at McGill University in Montreal, psychiatrist-in-chief at the Royal Victoria Hospital there and director of the Allan Memorial Institute of Psychiatry. Dr. Cameron received his medical education at the University of Glasgow in his native Scotland. Following his graduation he served residencies and assistantships in psychiatry in Scotland for several years, then came to the United States, where he was a member of the staff of Johns Hopkins Hospital. Later, he went to Zurich, Switzerland, to work in his specialty with Prof. Hans W. Maier.

In 1931, Dr. Cameron joined the staff of the Provincial Mental Hospital at Brandon, Man. In addition to his work at the hospital he undertook the organization of mental health clinics throughout the province. He remained in Manitoba for several years, then went to the Worcester State Hospital, Worcester, Mass., and, later, to the Albany Medical College, Albany, N. Y., as professor of neurology and psychiatry, where he stayed for five years before taking over his present position in Montreal. In December 1945, Dr. Cameron was one of three American psychiatrists selected to go to Germany for the purpose of examining Rudolf Hess and other Nazi war criminals at the Nuremberg trials. He is the author of several books on psychiatry and numerous contributions to the medical journals in his field.

Mabel W. Binner had her first glimpse of a hospital when, as a young girl, she was invited to visit a friend who was in training. This student nurse was so filled with enthusiasm for her work that she took her guest on a tour of the entire hospital. Miss Binner could scarcely wait until she reached home to tell her family she had filled out an application blank. In spite of family opposition, she entered the next class of probationers.

Following graduation from St. Luke's Hospital School of Nursing, Chicago, Miss Binner had varied experience in institutional, public health and the social service fields; as supervisor at St. Luke's; with the Association for Improving the Condition of the Poor in New York City; the New York Board of Health, and the New York Orthopedic Hospital. In 1922 she organized the Student Teaching Center of the Chicago Visiting Nurse Association. In 1924 she became director of the outpatient and social service departments of Children's Memorial Hospital, Chicago, resigning in 1929 to return to Teachers College at Columbia University. Within a few months she was recalled by trustees of Children's Memorial to become administrator, and she has held that position ever since.

During Miss Binner's administration a complete personnel program has been put into effect at the hospital, including a well organized employes' health service, vacations (with bonus vacation every five years) and recently a generous retirement plan for all employes having five years or more of service. Four new buildings have been added—a power plant, laundry, nurses' residence and clinic building. Miss Binner is a strong advocate of giving women administrators the same freedom enjoyed by men, who for the most part are not obliged to live in the hospital. She owns her home in the suburbs, which is shared by her mother and a teenage foster daughter. She enjoys antiques, music, books, gardening, picnicking and hiking, with one memorable 27 mile hike in one day to her credit. On that occasion, Miss Binner admits, however, she and a friend took the wrong trail and were lost most of the time.

David Littauer, M.D., first became interested in the problems of the long term patient when he was resident in medicine at Montefiore Hospital, New York, in 1935. After entering the private practice of medicine in New York in 1937, Dr. Littauer was appointed to the attending staffs of Montefiore and Goldwater hospitals.

Dr. Littauer served in the army medical corps for five years, passing through all grades from first lieutenant to colonel. A series of assignments as head of a school for medical department technicians, staff surgeon of the airborne command, executive officer in the medical section of the fourth army and commanding officer of the 86th Evacuation Hospital decided him in favor of administrative rather than clinical medicine on his return to civilian life. Early last year he accepted his present position as director of Menorah Hospital in Kansas City, Mo. Today Dr. Littauer is busy with expansion plans for the the hospital, which include provision for the care of approximately 50 chronically ill patients. He is secretary of the Kansas City Area Hospital Council and serves on a number of its committees.

Elon H. Clark is assistant professor of medical art and photography and director of the division of medical illustration at Duke University School of Medicine, Durham, N. C. He is also chairman of the board of governors of the Association of Medical Illustrators, an organization he helped to found several years ago. Mr. Clark studied art at the Rochester School of Technology, then went to Johns Hopkins to study medical art, then a comparatively unknown specialty, with Professor Max Brodel. Later, he became Professor Brodel's assistant. He joined the staff of Duke University as a medical artist in 1934.

THE ROVING REPORTER

History Was Made Here

Beyond the reach of the highest bidder is a fine old double desk with hinged covers that was a part of the hospital equipment at Massachusetts General in the early days of the Bulfinch building. The desk now stands in the Archives Room of M.G.H.

What makes the desk priceless is not its original design but some hand carving added later. In fact, the hand carving was done over a long period of years beginning in 1851 and ending in 1912.

Some of the carving is in a sort of cipher but the archivists have made out most of it. They have deciphered the names of nearly 200 house officers who sat at that desk over the years to write up histories and daily notes.

In the list of those who have initialed the desk appears the penknifemanship of Frederic A. Washburn and N. W. Faxon, two great names in hospital history. Many of the men have made medical history: Harvey W. Cushing, F. H. Albee and Hugh Cabot among others. Three generations of Homans are represented: 1861, 1882, 1903.

One part of the cipher is still unsolved: the identity of J.R. and S.C. whose initials appear on a bulging heart shot with Love's arrow. If one pair of those initials belongs to a reader or his descendant, please confess all for the M.G.H. historical record.

Add a Glaucoma Clinic

With only average good will, courage and stamina, the patient with chronic glaucoma gets disheartened in a busy eye clinic and after one or two years quits coming.

The eye clinic doctors in a crowded outpatient department find it difficult to devote the time and necessary concentration needed for the exacting, sustained follow-up essential in most chronic glaucoma cases.

These two wrongs can add up to a right situation if a glaucoma clinic is added to the general eye clinic. That is how it has worked out at Illinois Eye and Ear Infirmary, Chicago, according to Dr. Peter C. Kronfeld. In the pre-glaucoma clinic era, the "no-return" rate was 96 per cent; now it is 15 per cent.

At this specialized clinic the appointment system is followed so closely that no more than one hour of the patient's time is required. A close patient-doctor relationship is maintained, for the doctors do not change and at each visit the patient is examined and given advice by one of three regular physicians. The patient not only is closely supervised by an ophthalmologist especially interested in follow-up of the glaucomas but also is under the close supervision of a social service department familiar with the social aspects of this disease in its various forms.

This clinic has educational value as well, since each resident spends at least one half day weekly in the special clinic, examining the eyes of six or eight patients and reviewing and discussing their records with the supervising ophthalmologist.

They Convalesce at Home

It's a puzzle why a first class convalescent home in a large city should have vacant beds in these days when general hospitals are trying to discharge patients at the earliest possible moment.

Perhaps Mary Whitelaw, director of medical social service, Free Hospital for Women, Brookline, Mass., has the answer or, at least, one of the answers. During the war many mothers were employed and there was no one at home to give convalescent care.

With the war's end came an aggravation of the housing shortage. The veteran and his wife and the daughter and her husband are living in with Dad and Mother and there is always somebody around to wait on and perk up the convalescent.

Same holds with child placement and housekeeping services, Miss Whitelaw finds. Requests for both of these have declined.

Candid Microphone?

Rumford, Me., is still talking about the afternoon that Mr. R.C.H. spent with Mrs. A.C.

Apparently one of those candid microphone fellows was hiding behind the curtains and he recorded everything that passed between the two. The transcript has been put into mimeographed form and is being circulated all over the town. People are nodding their heads wisely, pretending they had long suspected the truth of some of the charges made and, by darn, they are going to do something to stop this turn of affairs or know the reason why.

Someone has written a foreword to the transcript, setting the stage for the little drama. From it we learn that the year before Mr. R.C.H. had paid a visit with similar intent. But this time things are different with Mrs. A.C. She has put on a few pounds and a contented look. There are some fine furnishings in the house and a new model car in the driveway.

R.C.H. is in grim contrast to all this. Thin, weary, harassed looking, he is wearing last year's old Palm Beach, a little frayed and shiny, though well pressed.

In the transcript itself there are precious few preliminaries until Mr. R.C.H. gets down to action. Pulling a sheaf of papers out of his bag, he cites an impressive record of what he has done for Mrs. A.C. in the year just gone and then gets around to showing, step by step, the frightful increase in the cost of keeping up an establishment of this sort over the previous year.

Mrs. A.C. is impressed and sympathetic even when R.C.H. bluntly points to a deficit of $9978. Well, we won't go into it all—possibly it isn't as alarming as it sounds here—but it is mighty convincing reading and we do not hesitate to recommend it—to adults only, of course.

Since we have gone this far without mentioning names, we might as well go the whole way—the transcript does from the beginning. We find that R.C.H. is none other than Rumford Community Hospital and everybody can guess that Mrs. A.C. is the attractive wife of Rumford's Average Citizen.

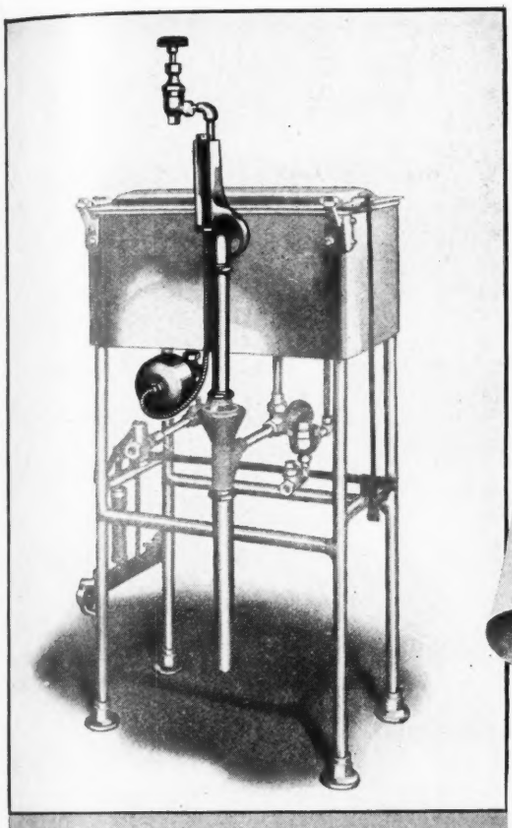
The mimeographed document that everyone around Rumford is reading is the hospital's annual report.

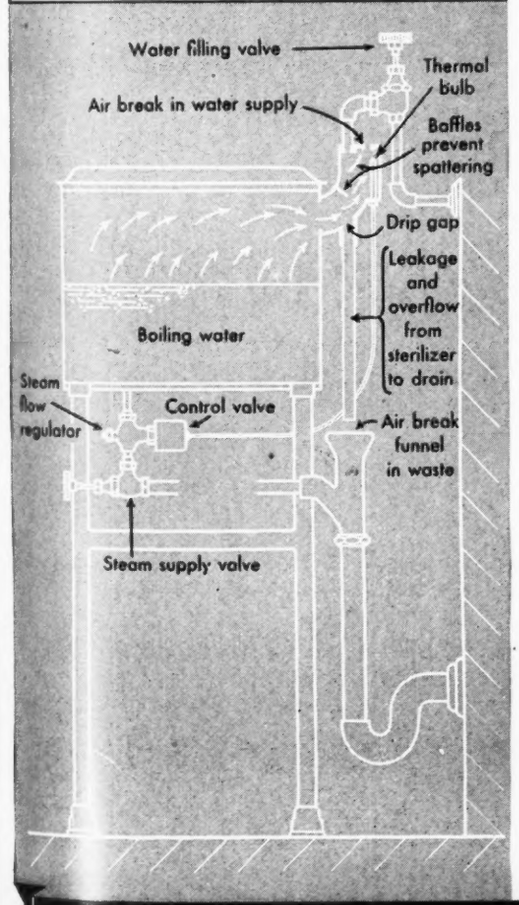
No Recession Here

Hospital gift shops had a good June because of weddings and graduations. At Presbyterian Hospital, Pittsburgh, the gift shop rush was almost up to the Christmas level.

Best sellers at this shop at this season are iced tea, water and juice glasses, mirrors, compacts (for girl graduates) and—this is a free plug—Twink-A-Toes, a new type of toy that utilizes static electricity. You rub a cellophane container and if you are a "generator" the toys inside begin to cavort in a captivating fashion.

PUTS EXCESS VAPOR TO WORK





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READER OPINION

Applause for the Doctor

Sirs:

I have read with a great deal of appreciation the article in your July issue, "A Doctor Speaks Up for the Nursing Profession." Many doctors undoubtedly share his conviction of the importance of better education for nurses, both as nurses and as human beings. Most doctors, however, either are unconscious of it until in a moment of crisis an unprepared nurse fails them or adequate numbers of nurses are not available or else lack Dr. Uyeda's courage and his felicity in expressing his point of view.

The demands for more and better nursing service which the nursing profession is trying to meet are not created by nurses, of course. These demands spring from social and scientific forces which exert pressure on physicians themselves, and also on the allied professions.

It is more than a little absurd that so much public lance-tilting has been going on in some quarters, to the obvious bewilderment of the community. But until the professions understand each other better, nurses are fortunate to have so able a champion as Dr. Uyeda in the lists.

We applaud your editorial judgment in obtaining and publishing the article. It will have a wholesome influence. We hope it may inspire other authors to promote positive values.

Mary M. Roberts, R.N.
Nursing Information Bureau
New York

Takes All Kinds

Sirs:

The management of this hospital is very grateful to the Blue Cross, as it has solved many of our financial problems. While we do not collect the entire amount billed against these patients, nevertheless, we feel that we break more than even. There are no bad debts to be charged off, and we know that many patients are paid for by the Blue Cross who would otherwise be in public wards, paying little or nothing for their services. . . .

Sirs:

The forgotten "ogre" seems to be the Blue Cross. I am speaking of the "ogre" that reaches into the hospital cash registers and discounts a lot of the legitimate hospital patients' bills at considerably below face value. Blue Cross started without funds. The accumulated surplus must therefore represent benefits which were not received by the subscribers or money which was not paid to hospitals. . . .

These are excerpts from two of the many letters received following the appearance of the article, "There Are Ogres in the Hospital Basement," by E. A. van Steenwyk, which appeared in The Modern Hospital several months ago.—Ed.

One Day Stand for Salesmen

Sirs:

I have always felt that the doctor generally is not too happy to have a hospital supply or pharmaceutical supply house detail man come into his office, taking time from the patients and perhaps coming in on an extremely busy schedule.

At least twice last year I offered the doctors' library and coat room to two of the drug houses and permitted them to set up a sample display of their wares, and they were only to answer questions of the doctors who came to visit patients in the hospital. They reported a very satisfying day and, of course, they saw perhaps 10 times the number of physicians in that period of time that they would have by going from office to office.

It has always been my belief that if a number of men or a representative group of the men on our staff make up their minds with respect to a specific piece of equipment, biological or any preparation to be used for the care of the patient, and their opinions were crystallized at the same time, it would simplify our problem with respect to what was necessary.

However, the time required to track down the individual men and obtain their opinions at widely separated intervals is not too productive. If, therefore, the most active men on our staff could be exposed to an exhibit in the hospital, set up by various suppliers, I could quickly obtain their opinion as to the specific item and feel reasonably secure in putting in that item.

Do you think that if I pursue this idea of mine and ask the major suppliers to set up one day stands in the hospital that I would be serving the doctor and the hospital to the best advantage?

Karl York
Administrator
Arlington Hospital
Arlington, Va.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Bed Falls

Question: We seem to have an unduly large number of people falling out of bed. We have been fortunate thus far in that we have had no serious results from this type of accident. However, a bad case is bound to come along unless we do something about it. Other hospitals undoubtedly have the same problem, and I am wondering about the feasibility of sideboards for all beds in the hospital. We use sideboards on several of our beds now where the need seems to be evident. I realize that sideboards on all beds would be a hardship for both nurses and doctors, as they would have to be raised and lowered so many times. What is the experience of other hospitals?—B.P., Tex.

ANSWER: The same problem exists in all hospitals, to a greater or lesser degree. A careful analysis of these incidents in one hospital over a one year period indicated that a majority of the falls were suffered by patients over 50 years old. Further analyses revealed that they followed pretty closely certain types of clinical cases. Standard practice instructions were therefore issued calling for the routine installation of sideboard protective devices for all the types of patients and all patients in certain age ranges that experience indicated were hazardous from the standpoint of bed falls. By this method, approximately 80 per cent of these falls were eliminated.

Most hospitals should be able to achieve similar results by making a careful analysis, with the help of the medical staff, of all such accidents and taking protective steps as indicated by the results of the study.—E. W. JONES.

It's the Patient's Choice

Question: What should be the attitude of the hospital when patients are taken out of the hospital to have x-ray tests made, when the hospital has an accredited x-ray department and radiologist?—Sr.C.M., N. M.

ANSWER: What possible concern can a hospital have in the question of whether patients are examined by the staff radiologist in the hospital department or in the private office of a radiologist? If the patient or his attending physician desires that the patient receive a roentgen examination from a radiologist who is not a member of the staff, nothing should be allowed to interfere with that choice.

A particular clinical problem may call for consultation with a radiologist known to be especially skilled in that condition but who does not happen to belong to the staff of the hospital in which the patient is hospitalized. In such cases, he should be permitted to come in and use the x-ray department in that hospital, or the patient should be sent to him. After all, there are different degrees of skill among radiologists as there are among surgeons.

The American College of Radiology has always maintained that a patient should be entitled to free choice in the selection of a radiologist as in the case of other clinical specialists with due regard, of course, to practical consideration and reasonable administrative policies.—MAC F. CAHAL.

Rates *v.* Costs

Question: Have hospital rates (charges for rooms and service) increased commensurately with the increase in hospital costs over the past few years? How much have costs gone up?—E.E.D., N. J.

ANSWER: I have recently studied the figures in a few representative hospitals and find wages and salaries have increased from 50 to 100 per cent in many categories of help. For example, in a well known hospital in Ohio food and supply costs have risen between 40 and 50 per cent in the last five years.

On the whole, hospital rates have not increased in proportion to the increase in operating costs. By and large, rates to the public have increased about 20 to 40 per cent. In many hospitals, the biggest financial headache is still the abnormally low rates paid by state, city and county governments for the care of home relief clients and the medically indigent. For instance, in one state the rate paid all hospitals for care of the indigent is still $4 a day. This is to be compared to an average cost per patient per day of approximately $8.50 in that state. Five years ago the cost in this same state averaged $6.50 per patient day.

Some figures compiled by Blue Cross groups indicate that operating costs per patient per day in member hospitals of Blue Cross plans throughout the country increased by 40 per cent from 1941 to 1945. There was a further increase of 20 per cent from 1945 to 1946.

The following information on starting salaries for graduate staff general duty nurses in hospitals may also be of interest. In 1940 the starting salary, that is, total cash plus estimated value of board, room and laundry, ranged from $100 to $110. A rather comprehensive survey recently completed shows that in 1945 this had risen to $155; in 1946, to $172, and from present indications this figure will be pretty close to $190 by the end of 1947. In many metropolitan areas and a considerable number of reasonably sized urban areas, the figure right now runs between $200 and $210.

This is starting salary, and in most well organized hospitals there is an increase of $5 each six months until a top salary for a general duty nurse reaches from $215 to $230. These figures, of course, indicate about a 90 per cent increase in the starting salary of graduate staff nurses. The reason that overall per patient day costs in hospitals have not increased more than they have is that hospitals have been unable to hire as many employes as their organization calls for.

Nevertheless, it is my impression that, on the average, hospitals are better off financially now than they were from 1930 to 1940. Fortunately, there has been a noticeable trend toward increase of payments to hospitals from governmental units for the care of the indigent.—E. W. JONES.

Why Are They So Dirty?

Question: In looking around hospitals one gets the impression today that they are not as well kept as they were seven or eight years ago. Not only is there a tendency toward shabbiness, but also the equipment seems to be rather old and battered. Is this condition common?—E.E.D., N. J.

ANSWER: The shabby look in many hospitals today as compared with seven or eight years ago probably results from inability to employ unskilled labor for cleaning in competition with industry. It was my recent experience in a city hospital of good reputation that the place was just plain filthy, owing to (a) bad building plan with extremely high ceilings, (b) bad location in relation to dirt sources and (c) inadequate help and resultant overloading of help on the job.

The last cause goes back to hospital wage levels. Until hospitals can compete for labor with surrounding industry, or until there is a general slackening of employment, hospital prosperity alone can do little about the situation.—R. T. S.

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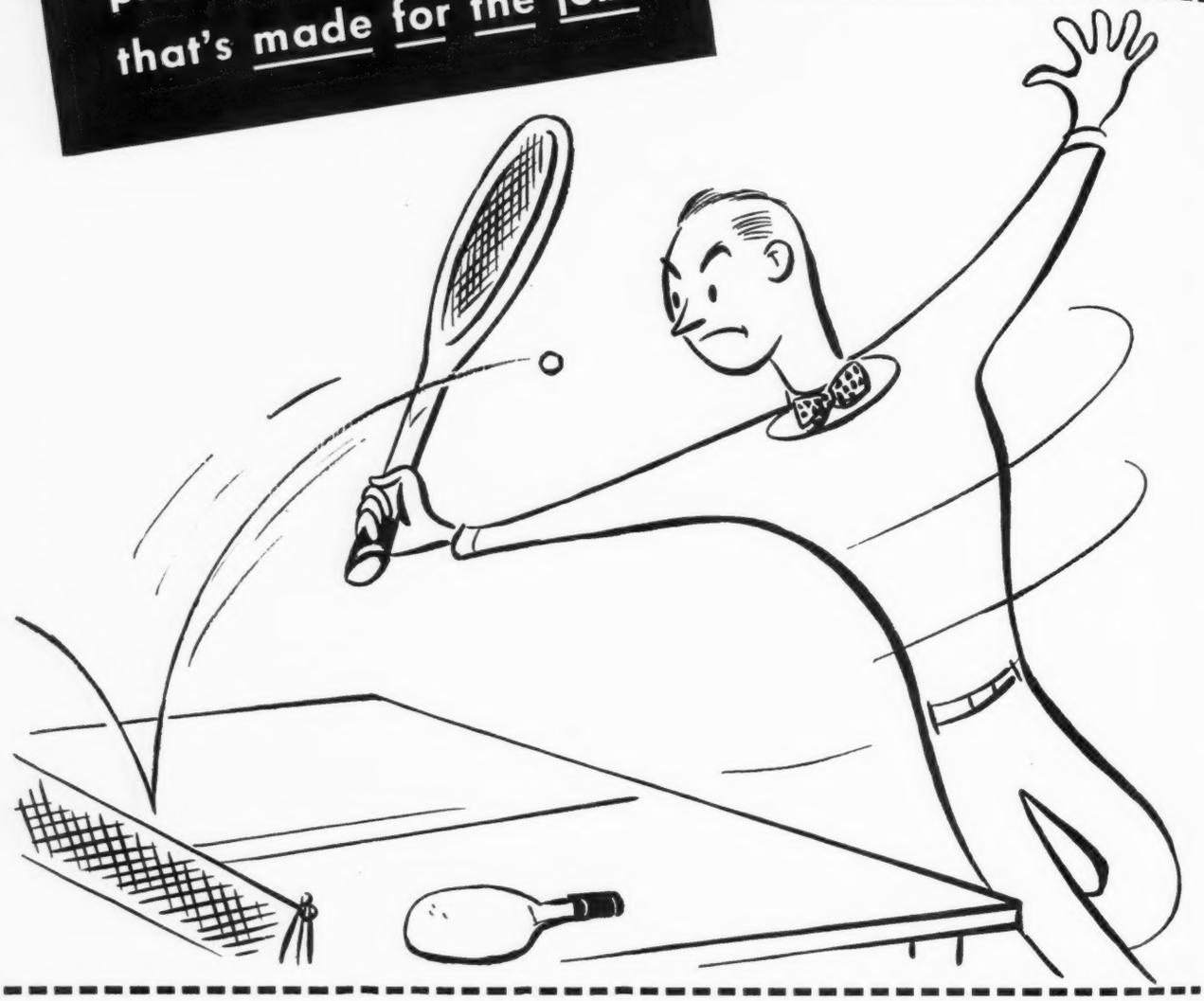

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LOOKING FORWARD

Differences That Count

THOUGH it is emerging steadily into the light, hospital administration still lies partly within the shadow of its humble origins. For all the exacting complexity of their responsibilities, today's administrators remain the occupational offspring of yesterday's hospital matrons and wardens, whose job was to count the sheets and the pennies and keep out of the way of their social and intellectual superiors.

Some administrators are content to spend their whole careers within the limitations imposed by this inheritance, bowing invariably to the hospital trustees on matters of business and to the staff on matters of service, eagerly and a little nervously performing the bidding of either group, and expressing themselves only in the narrow range of thought between "Yes, sir," and "No, sir." These administrators do their work as competently as their abilities permit, and no doubt some of them are able enough, but actually they have little to do with whether the patients in their hospitals get good care, or whether the communities they serve get their money's worth.

Fortunately, many administrators have refused thus to submerge themselves. These are the men and women who treat and are treated by the board and staff as equals, who stand squarely for good principles of patient care and efficient operation, who lead, instead of curtseying to, the thinking of trustees and doctors. These are the men and women who are molding hospital administration into the shape of a profession.

Now, what is the difference between the truly professional administrator whose position is one of genuine leadership and authority, and the person who simply answers to the title? Part of the difference, it must be acknowledged, is in salary. Possibly it is a bad one and ought to be abandoned, but money is a major yardstick of esteem in our American economy. The administrator who sells his services cheaply may do so from the purest motives of service to humanity, but he is nevertheless seriously limiting his effectiveness when he does it. Trustees will never really value a judgment which they can buy for a clerk's wage. It is too bad that it is so, but the fact is that the badge of authority shines dimly on a frayed suit.

Another part of the difference is preparation for the job. Whatever his abilities, the administrator who comes cold to the hospital field is at a disadvantage. He may be dead right, but who can have confidence in his opinion on the kind of technical problem that occurs daily in the hospital? The executive with training or experience in medicine, in nursing or in hospital administration itself, on the other hand, immediately commands the respect of his or her associates. Other things being equal, the more training and experience, the more respect.

A general education and cultural background that permit the administrator to meet board and staff members on their own social level must also be counted. This does not mean that the administrator must trade dinner engagements with the board president and the chief of staff; whether this is done or not is unimportant. It means only that these things, too, are a part of our currency of esteem; to carry weight as a person as well as a technician, the administrator must have an appropriate share of the general currency.

The greatest difference of all, however, is one of personal qualification. The administrator with high vision, firm courage and a talent for human relationships can give away every advantage of salary, preparation and cultural background, and yet rise to the full opportunity offered by his position. With perception to see the truth and character to make it stick, no man or woman can fail the deep responsibilities of hospital administration. These are the values Tawney referred to when he said, "The essence of a profession is that, though men enter it for a livelihood, the measure of their success is the service which they perform."

Danger!

HOSPITALS operating blood banks must take warning from recent studies showing that infections can easily be transmitted by plasma obtained from infected sources. The practice of pooling plasma for blood banks, it is pointed out, is especially dangerous because of the possibility that some of the material comes from donors whose medical records have not been checked with sufficient care. A number of cases of infectious jaundice, some of them fatal, have now been traced to plasma obtained from donors who had previously been infected. Except to rule out syphilis, malaria or acute current illness, screening of donors has sometimes been careless, investigators have found.

Some of these hospitals, too, it develops, are not above accepting blood from indigent, anemic and often alcoholic donors who sell blood at too frequent intervals

to get money for liquor, and whose health is endangered by the practice.

Administratively, it is suggested that hospitals with blood banks immediately establish foolproof procedures for eliminating donors who have had hepatitis, or have been in contact with any person suffering from jaundice, in the preceding year; those who have received blood or blood derivatives; those who have been hospital patients, and those who are anemic, undernourished or show any signs of alcoholic overindulgence. Careful records must also be kept and exchanged among hospitals in the same area to rule out repeated donations at short intervals from the same source. Eight weeks is the minimum interval between donations; many physicians recommend ten to twelve weeks for safety.

These and other problems which have developed in the operation of hospital blood banks should certainly be discussed with appropriate representatives of the medical staff, who may wish to review the literature and set up additional safeguards, if not to establish regulations aimed at reducing the number of patients to whom plasma is given when indications for its use are doubtful.

Best Defense Is a Good Offense

A STATE welfare director who has been working conscientiously with hospitals for several years to increase the amounts of payments made by his agency now writes that, in an economy mood, legislators are about to undertake an investigation aimed at reducing the cost to the state of caring for the indigent sick. Plainly, the likelihood is that hospitals there are going to take it on the chin again.

The chances are, however, that those hospitals will be damaged least which can produce the most conclusive evidence that present welfare payments are below the actual costs of welfare services. Hospitals with airtight cost accounting systems will fare better than those whose cost figures are questionable. Similarly, those whose reports reflect efficient management are more likely to come out whole than are institutions in which gimlet-eyed investigators can point to waste, extravagance or inefficiency.

Whatever happens as a result of this investigation, here is a warning for hospitals everywhere: The costs of hospital care have advanced to a point at which questions are going to be asked—if not by legislatures, then by other contracting agencies, or by the public generally. From now on, hospitals must be prepared to give specific, informative answers to such questions if they are to enjoy public support and confidence. The best procedure of all from the standpoint of public policy is to give out the answers before the questions are asked. In a public meeting sponsored by hospitals and widely reported in the newspapers, for example, the hospitals of Cincinnati recently explained to the community why costs and prices were mounting.

This is a wholesome development which should be undertaken elsewhere. Hospitals cannot continue to provide good service unless the public will pay for it, and there are indications that the public may be unwilling to pay what good hospital care costs today unless it is persuaded to do so by intelligently planned public information services.

Save on Stores

ADVERSITY sometimes has its advantages. The stern laws of economics are forcing hospitals to effect operating savings at every possible point without sacrificing quality service. This is a good thing—though necessity is certainly not the preferred route, or the only one, to efficiency.

One way to save money, many hospitals have found out in these times, is by the introduction of systematic, economical purchasing procedures. Especially in small hospitals where purchasing is the function of the administrator or of one or several department heads, there is often no organized effort to estimate needs over a long period of time, to weigh the comparative costs of quantity purchase and storage as against short term buying in every major line, and then to establish purchasing policies and methods according to the most economical indications throughout.

Where such recognized good business methods are missing, purchasing is often a series of mad scrambles to fill immediate needs. Price and quantity advantages, which may be considerable, are lost under these circumstances and frequently embarrassing shortages develop. Examination and improvement of purchasing practices will offer many hospitals a real opportunity to check rising costs. Simultaneous improvements of this nature in a large number of hospitals will soon enable manufacturers to estimate demand more accurately and schedule production more economically.

Newcomer

THE American Hospital Association has announced forthcoming publication of a monthly journal for hospital trustees. According to the announcement, the new journal, which is to be called, reasonably, *Trustee*, will circulate free to board presidents of A.H.A. member hospitals, at $2 a year to administrators and board members, and at $3 a year, or cost, to other subscribers.

The new journal will be welcomed by thoughtful administrators and board members who recognize that the trustee's responsibility extends far beyond the social and fund raising obligations that are accepted routinely. For several years, interest in the Trustee Forum of The MODERN HOSPITAL, reprints of which are circulated to thousands of hospital trustees every month on a group subscription plan, has indicated the need for a more elaborate program of trustee education, carefully planned to catch and hold the attention of the busy man or woman for whom the hospital is only a fractional interest.

To the extent that the new publication can fill that need, it will contribute to the cause of better hospitals.

How Can the Hospital Control Medical Quality?

A MODERN HOSPITAL Round Table

A HOSPITAL is either a group of people organized to care for the sick and injured, or it is simply a workshop in which licensed physicians may care for their patients as they see fit. Thoughtful people in the medical and hospital world are divided in their opinions on the challenging and controversial issue of administrative responsibility for control of medical quality in hospitals.

To discuss this and related problems, The MODERN HOSPITAL invited a group of interested medical and hospital authorities to its editorial offices in Chicago a few weeks ago. Taking part in the discussion were: Josiah J. Moore, M.D., pathologist and treasurer of the American Medical Association; Robert F. Brown, M.D., medical director and assistant administrator of St. Luke's Hospital, Chicago; Mac F. Cahal, secretary and general counsel of the American College of Radiology; Frank F. Selfridge, president of a hospital board of trustees, and Robert M. Cunningham Jr., managing editor of The MODERN HOSPITAL.

So that all our readers might sit in on this lively and significant discussion, we had a stenographer in the room taking down everything that was said. In the following pages, The MODERN HOSPITAL presents a transcript of the discussion, condensed somewhat to eliminate repetition and duplication.—*The Editors.*

MR. CUNNINGHAM: Possibly the best way for us to begin our discussion about the hospital's responsibilities for medical quality and medical judgment, which is what we are gathered to talk about this afternoon, is by reference to the article "Unnecessary Operations," in the *Woman's Home Companion* last month.

Whether we all approve of the article or not, we can probably all agree with the main point it makes: that some bad work is done everywhere, in good hospitals as well as bad hospitals. Now the point is, what is the hospital's responsibility for preventing and trying to improve this situation? How far can the hospital go?

Our interest here is chiefly in providing assistance for the hospital administrator and the hospital governing board. These are medical problems. Where does the hospital's responsibility for this kind of thing begin?

DR. MOORE: I would say you have two responsibilities. One is the administrator's and the other the medical staff's. The staff should direct everything in medicine, but too frequently the staff members, not wanting to hurt one another's feelings, will not take the responsibility that they should take in these matters.

MR. CUNNINGHAM: That's it. So who picks up the ball? Mr. Selfridge here is a hospital trustee. These problems, ultimately, become the responsibility of the governing board. Sure, they are problems that should be dealt with by the medical staff, but when that doesn't happen spontaneously, what are the steps? What must be done? Who must do it? Where do you begin?

DR. BROWN: It seems to me that there must be a cooperative effort between the administration and the medical staff. It is the responsibility of the administrator to stir up the members of the medical staff and keep them on the ball, to keep them pointing like a beagle toward the objectives of top-notch medical quality. When errors are committed, or bad surgery is committed, then certainly such work should

be reviewed by the medical staff and administrator and a decision reached as to what these bodies should do—cooperatively.

DR. MOORE: All the medical work, however, should be supervised by the medical staff, and the administrator should not do anything until he has consulted with the medical staff.

DR. BROWN: From the point of view of operation, it is probably necessary to have an advisory committee of some type within the medical staff, whether it be the overall staff organization or simply a disciplinary committee or medical advisory board, to sit with the administration in developing the self controls. But I certainly don't want you to draw me out as saying that the administration should take this authority away from the medical staff, because I believe it belongs with the staff.

MR. SELFRIDGE: Does it belong there under ideal conditions, or always?

DR. BROWN: Always.

MR. SELFRIDGE: I am thinking of this: In our hospital as well as many others, I suppose, there are members of the staff who are not qualified to do all types of surgery. Yet they all hesitate to speak out publicly about the qualifications of another doctor.

Now, my board has taken a very active and a very sincere interest in the medical aspects of our hospital. We have suggested mildly on occasion that this or that should be done, and it hasn't been done. So we have said to our superintendent: "We want you to be familiar with everything that goes on in that hospital. If a doctor does something that he shouldn't do, we want you first to take it up with the staff. We want you to get action, and if you don't get satisfactory action, we want to know about it."

Now, that has had a salutary effect. The men we have wanted to circumscribe are changing their attitude. They are beginning to seek consultations and they are beginning to want to do better work. We proposed to just bear down on that end of it to the end that we can do anything in that hospital that our community demands to be done with the exception perhaps of the more difficult special types of chest surgery or brain surgery, or something like that.

DR. BROWN: Can we approach this through a specific question?

MR. CUNNINGHAM: Anything goes.

DR. BROWN: What would you do as a hospital administrator if you received a communication from one of our approving bodies that your cesarean rate was, say, 5 per cent, and the approved overall average for the country is 2 per cent?

JOSIAH J. MOORE, M.D., is a pathologist on the staff of several Chicago hospitals and director of the Moore Clinical Laboratories there. He is treasurer of the American Medical Association, a past president of the Chicago Medical Society and a diplomate of the American Board of Pathology.

MR. CUNNINGHAM: You are the administrator who receives this reproachful communication, which makes it your move?

DR. BROWN: Yes. Now what would you do?

DR. MOORE: Well, if I were the administrator I would immediately hand it to the obstetrical staff and if it were a small hospital where everybody does obstetrics, or practically everybody does obstetrics, I would give it to the general staff, so everybody could be in on the discussion. Then I would suggest to that staff that they review their obstetrics or the cesarean rate for the last two years and compare it with other hospitals in the same community and then with the country in general, and then have some qualified obstetrician discuss these cases separately and see whether they were not doing too many cesarean sections. That is the only way we can learn in medicine.

DR. BROWN: I agree with that.

MR. SELFRIDGE: We had that problem specifically. The last inspection we had by the college bore out that point that we were slightly above the national average in cesarean sections, and we handled it, Dr. Moore, exactly as you outlined. That is, we said to the chairman of the O.B. department, "We have suspected this for some time. Let's have the answer. We would like to have you analyze every cesarean section that has been done in this hospital in the last year and let us know about it." He came back with the report that, because of our particular situation, a goodly number of these patients had come by reference from outside doctors not on our staff and in some cases outside the district. The cesareans were done, however, in our hospital, so we got credit, or discredit, for that rate. Taking those out, our average was well below the national average.

DR. MOORE: So you had an explanation for that.

MR. CAHAL: What is the situation in relation to this question? When a complaint comes to the hospital administrator about the quality of medical care rendered in the hospital, it is inconceivable to me that the hospital administration can dictate policies to the medical staff. All it can do, I think, is to refer that complaint to the staff, and as a practical matter that is what they always do as far as I know. What else could they do?

The medical profession is a self policing profession. There is nobody else to police it. Even the courts can't police it. It is policed by a code of ethics that doctors have imposed upon themselves. There are some scalawags in the medical societies and on hospital staffs, but there is no practical way you can police a staff except by the staff itself. How is a nurse or a lay superintendent going to know what doctor performed an unnecessary operation? It is not possible. In order to police a hospital staff and maintain the highest quality of medical care, I think the hospital can rely upon nothing except its own staff.

Now, I would like to ask a question. What is a hospital? Are the hospital administration and the hospital staff two separate entities?

MR. CUNNINGHAM: No.

MR. CAHAL: When you say how can the hospital do this, you mean how can the administration and the staff do it together, is that right?

MR. CUNNINGHAM: Yes, I think so. You have to consider the whole group.

MR. CAHAL: I think that is important. I think the word hospital means the staff and the administration together, and so when you ask the question, how can a hospital maintain a high quality of medical service, I think you mean how can the medical staff do it, because I don't think the administration can.

MR. CUNNINGHAM: But Mr. Selfridge has described a situation in which the administration and the governing board were the prime movers.

MR. SELFRIDGE: Right.

DR. BROWN: We are a little ahead of ourselves now. All of us have at one point or another tried to drive a wedge between the administration and the medical staff, which is all wrong. That ought to be withdrawn from our conversation. Rather, we should go back and say that the hospital, in order to correct these things and to answer the question that Mr. Cunningham asked, must first of all organize itself and have the medical staff organize *itself*. Then the hospital is in a condition to police these abuses we have been speaking of. It is a cooperative effort of all the hospital—and now I hesitate to use the words administration and medical staff, because the thought should be all inclusive.

I assume, Mr. Selfridge, that that is exactly what you folks did in your approach to your problems—that is, to carry these problems of medical administration to the medical staff organization, and then follow through and see that they come back with an answer.

MR. SELFRIDGE: But you see, Doctor, in our case the medical staff didn't take the initiative. It was the lay board.

DR. BROWN: You have to take the initiative to stimulate the medical group to organize itself and that is an administrative responsibility.

MR. CUNNINGHAM: Say I am the administrator, a layman, of a hospital. It has 75 beds and it is off in the country some place and we have an organized staff. We have committees. We have staff conferences. We have all the stated requirements of staff organization. I read this article in the *Woman's Home Companion* or I hear about an incident or something happens, and I am unhappy.

There are things here I am not able to judge. I don't know how to investigate or to evaluate the work that is being done, but the chances are some of it isn't as good as it ought to be. We have a staff committee. The staff committee is composed by and large of the people that are doing this work that I am inclined to be critical of without knowing what I am talking about. What do I do? If I try to get improvements through these committees, they will probably throw me a fish: Everthing is fine. Everything is going along fine.

Where do I begin, or am I doing everything that needs to be done? Am I fulfilling all my obligations, and are the trustees who employ me fulfilling all of their obligations, if everything *looks* all right?

ROBERT F. BROWN, M.D., is medical director and assistant administrator of St. Luke's Hospital, Chicago, where he has been for two years. Before going to Chicago he was assistant superintendent of Stanford University Hospitals in California and chief resident at the Sonoma County Hospitals, Santa Rosa, Calif.

MR. CAHAL: You are assuming, aren't you, that there is a tendency in medical staffs of hospitals to protect incompetents? I think the tendency is quite the reverse. I think the doctors on the staff themselves are the most hypercritical of incompetents.

DR. BROWN: If that were true, we wouldn't need this meeting.

MR. SELFRIDGE: Among themselves, Mr. Cahal.

MR. CAHAL: The Philadelphia County Medical Society has formed a committee and has required that every doctor who treats a malignant tumor must come before that committee and make a full report of the case, his diagnosis and his treatment.

DR. BROWN: You are answering your own question. A medical audit is done there.

MR. CAHAL: By the medical profession.

DR. BROWN: That is what a medical audit is. That is the answer to your question—the necessity for repeated medical audits. That is the medical staff's job.

DR. MOORE: One of the groups that passes upon the qualifications of hospitals requires a monthly staff meeting. The thing that they are interested in, and the thing that isn't done in the majority of the hospitals in the United States, is the medical audit. That is the report on all the cases in that hospital for the preceding month. But hospitals and doctors in many cases do everything they can to get around actually having their medical audit.

MR. CAHAL: Now, in my work in this field this hypothetical case doesn't ring true to me when Mr. Cunningham says that this harassed superintendent of a 75 bed hospital in a small rural community goes to the staff and the staff throws him a fish. In my experience the staff doesn't do that because they are competitive in the first place. They are very critical of their colleagues, and too often my experience is that the reverse is true, that they are the ones that are carping about their own colleagues on the staff. I remember how the doctors on one staff went after one man for performing an unnecessary operation simply because his fee was $25 for an appendectomy, while the rest were charging $75. As far as I know that was the only difference.

I would like Dr. Moore and Dr. Brown to answer this question: Do you think that hospital staffs willingly cover up incompetency in the hospital?

DR. BROWN: Except for the word, willingly, yes. The thing that happens in hospitals where this does occur, and believe me there are such hospitals, and not just a few, is that there isn't staff organization. That's really the kernel of this thing. I believe that where you have organization with administrative cooperation you don't have this problem in a large way. But there are hospitals in this country which are just places where individual doctors take their cases and do whatever they darn please with them and send them home and that is all there is to it.

MR. CAHAL: I know that.

DR. BROWN: Now, in that kind of hospital you are going to have abuses, but in the hospital where the doctor is a member of the medical staff and where he takes his case in and treats it and then at the monthly medical staff meetings there is a medical audit, the picture is entirely different. The medical staff does control itself then. It seems to me that the function of the administration is merely to see that the medical staff organization is developed. But in the kind of hospital to which a doctor takes a patient, almost the way you go down to a hotel and rent a room and then check out in a day or two, you do have these abuses.

MR. CAHAL: I know that type of hospital.

MR. CUNNINGHAM: Which type prevails?

DR. BROWN: You mean in numbers?

MR. CUNNINGHAM: Are there more that are honest to goodness organizations where they are making a sincere effort to evaluate their work

and keep it good, or are there more where it is just done?

DR. MOORE: That is easy. There are 7000 hospitals in the United States, including mental and tuberculosis hospitals, and the College of Surgeons has only approved with their minimum qualification some 2800 general hospitals.

MR. CAHAL: There are only 1500 general hospitals with over 100 beds.

MR. CUNNINGHAM: You can't say a hospital has only 50 beds and forget about it. That is where America gets its medical care.

DR. MOORE: So many of those hospitals that have only 25 or 30 beds do not meet the minimum qualifications for approval. The big requirement is that the staff be organized and have a monthly medical audit. Of course, hospitals with less than 25 beds are not eligible for approval.

MR. CAHAL: I think the greatest evil—and I believe the day is passing rapidly and the American College of Surgeons as well as the Council on Medical Education and Hospitals of the A.M.A. deserve the credit—I believe the greatest evil has been in these small hospitals where a single surgeon had an enormous amount of work. He was only a fair surgeon, perhaps, but he filled 40 or 50 per cent of the beds. He *was* the hospital. He dictated and dominated it and everybody else was afraid of him.

MR. SELFRIDGE: You haven't convinced me that it is the medical staff in these cases that has taken the initiative. In my case it was the board. The medical staff did not take the initiative.

MR. CAHAL: The complaint came to the administration and what did you do with it? You turned it over to the staff, didn't you?

MR. CUNNINGHAM: Apparently they didn't do that.

MR. SELFRIDGE: We didn't turn it over to the staff. We directed the staff to organize themselves, I mean with a set of rules and regulations which prescribe the qualifications necessary for members of the staff to practice major surgery and major obstetrics.

MR. CAHAL: I don't know how it could have been approved without such rules.

MR. SELFRIDGE: There was a staff organization.

MR. CUNNINGHAM: That is what I was talking about—the appearance of organization doesn't always mean effective organization.

FRANK F. SELFRIDGE has served for four years as president of the board of managers of the Highland Park Hospital, a 60 bed institution serving a suburban community of 20,000 people on Chicago's North Shore. Mr. Selfridge was a trustee of the hospital for many years before taking over the presidency. His business is banking.

DR. BROWN: And that doesn't mean that once you get it organized it stays there. Many, many hospitals slide back. There has to be continual policing.

DR. MOORE: I will go further and say that if there isn't continual policing we will always slip back. The situation is greatly improved, but it can still stand 100 per cent more improvement.

Mr. Selfridge is right when he says they had to get the staff organized to go over what they were doing and see if that could be improved. They weren't policing themselves, because they didn't want to hurt each other's feelings.

It took one hospital I know about ten years to get a surgical committee to pass upon the surgery. They would not pass upon it. No one would act as a member of that committee. They weren't going to police their brothers. After a period of ten years they got a committee appointed that would go and check up on the surgery. What brought that about was the lack of hospital beds due to the increase in income of people and hospital insurance. In my opinion, that surgical committee would not yet have been appointed except there was such a desire for hospital beds that the surgeons were fighting and criticizing each other because they couldn't get their patients in.

MR. CUNNINGHAM: It was an economic pressure. Now, what about the answer Mr. Cahal advanced a little while ago—the beautiful feeling that you leave all this to the doctors and they will take care of it themselves?

MR. SELFRIDGE: Again, this came from outside the hospital, outside the staff. They didn't start it.

DR. MOORE: I agree with Mr. Cahal in this respect, that the medical profession has pulled itself up by its own bootstraps all the way through. While the individual staff may not have done it, it was a group of doctors that started the College of Surgeons. It was another group, the American Medical Association, that started the study of medical schools and improved them. It was this same group that started the study of the training of interns and residents in hospitals. All were doctors, but the individual hospital had to have a stimulus from the outside to get its own staff working.

MR. CAHAL: All I can say is, it is a pretty bleak picture you paint if, after hospital beds became hard to get, they started to stop doing unnecessary operations and only do the necessary ones.

DR. BROWN: It is a real picture, whether it is pretty or not.

MR. SELFRIDGE: I have been sadly disillusioned. I was raised with a couple of doctors who were high minded with their patients and themselves, men on whom I placed reliance in my job, who I thought were fearless. They were the first to say, "Hang this fellow and get him out of the staff!" But when it comes up in a meeting they weasel on it.

DR. MOORE: I know of a hospital staff that last year took four men who were doing surgery and told them if they wanted to do major surgery at this hospital they would have to have one of the other men with them. They could do minor surgery, but where major surgery was concerned they would have to have other colleagues who were considered more competent assist them or take charge of the operation, whichever way you want to put it. Two of the physicians left the hospital staff. Two stayed on.

Now, I am always opposed to having them leave the hospital staff, because they will just go to some other place and continue their poor work there, while if they stay in their own hospital and their own doctors help them out, as they should, they will do better work on their patients. We have no way of stopping any doctor from doing anything except by taking his license away from him, and they have to commit a terrible act to have their licenses taken away.

MR. CAHAL: Please, let the record show that there are hospitals that are doing what you just described.

DR. MOORE: Yes, we are getting

better. We do learn from error, because it may help someone in the future to stop committing the same error. You can't get good medicine until we come out and talk about these cases.
MR. SELFRIDGE: That is what I have been hollering about for four years.
DR. MOORE: I have been hollering about the pathologist now for thirty-five years. It was the pathologists who put through routine blood counts and urinalyses. We did it for nothing because the doctors didn't want it, didn't want their patients to pay for it. The pathologists put through the routine Wassermann on every patient that came to the hospital long before the doctors approved of it. We put through the routine examination of all tissues before the College of Surgeons was founded, and we did it all for nothing at first. Later, we got a flat fee and now we get something like a fee for the service rendered, but it was hard going. I am just showing you what medicine has accomplished. We still have a terrible fog around our shoulders that we have to push and push and push away to come up for a little fresh air.
MR. CUNNINGHAM: Here is something else that I would like to have talked about: What are the things yet to come that have the same relationship to the type of medicine practiced now that blood counts and tissue examinations had to the kind of medicine you were trying to improve 25 years ago? What about the suggestion by a surgeon in Milwaukee that the hospital organize a consulting service, a mandatory consulting service in surgery and obstetrics, and that the hospital become responsible for making certain that all surgery except extreme emergencies be done only after consultation by appointed consultants? Is that something new?
DR. MOORE: No, that has been done for years in one city that I know. They started a consultation service for every major surgical case. An attending physician could call any man he wanted as his consultant, at any time of night or day. It was a free consultation.
MR. CUNNINGHAM: Are there many staffs doing that? Should the idea spread?
DR. MOORE: Sure it should. You ought to have a consultation on every surgical case. Hospital authorities now ask for more postmortems. I think we should have a few more consultations before the patients die rather than after they die. I would require consultation on every major surgical case, consultation by a medical man, not by another surgeon.
MR. SELFRIDGE: Even one who is qualified and trained?
DR. MOORE: I wouldn't care who he was. I would make it universal.
MR. CUNNINGHAM: Would you recommend that the hospital which has effected the reforms or the improvements we have been talking about step up now and slap on a rule for consultations?
DR. MOORE: There is no use slapping on a rule. If you slap on a rule and get your doctors antagonistic, you can't get any place. All these things have to come by education. You have to go and work and work and work.
DR. BROWN: Of course, the most important key peg in this control is the pathologist. You have to have a competent pathologist in your hospital. Then there are some other indices that go along with this. The autopsy percentage has been mentioned. That is one of them. There are others.
MR. CUNNINGHAM: What about the consultation index?
DR. BROWN: I agree with that. In the medical school hospitals where you have consultation rules in effect, you see the very finest type of surgery practiced.
DR. MOORE: And the finest type of medicine all the way through, because there is no hesitancy in calling in anybody they want.
MR. CUNNINGHAM: What about the hesitation that develops because it is going to cost the patient another $25 or $50?
DR. MOORE: What we are now trying to teach is that to make better medicine in a hospital, these consultations should be at a minimum fee or at no cost whatsoever.
MR. SELFRIDGE: Hear! Hear!
DR. MOORE: Here is this Hill-Burton bill. They are going to give communities money to help build hospitals, and they will say, "Doctors, here is a wonderful hospital for you. Everything is there but the doctor."

No matter how bad the building, and even the equipment, if you have a wonderful doctor in there it is a wonderful hospital, and it doesn't matter how good the equipment is and how wonderful the building is if you have a dumbbell in there.
MR. CUNNINGHAM: Here is another proposal: Bertram Bernheim, who wrote, "A Surgeon's Domain," proposes that all surgeons should be on salaries.
DR. MOORE: Well, there was another man who said that as soon as we get health insurance—
MR. CUNNINGHAM: I am not talking about that—
DR. MOORE: This man said that socialistic and government medicine will answer the problem. That will not answer the problem. It will make it ten times worse, because it removes the incentive.
MR. CUNNINGHAM: I wasn't referring to that but probably it is the same principle. In this book Bernheim proposes that in order to eliminate the profit incentive toward surgery, doctors should be paid salaries by the hospital organization.
DR. MOORE: Salary is not the answer. The teaching hospitals have better medicine than hospitals that are not university connected.
MR. CUNNINGHAM: I think it is a silly solution anyway because I don't think you can make wicked people good by changing the way you pay them.
DR. MOORE: The only way we are going to do some of these things is to have two goals: One is consultation on every major surgical case. How are they going to pay for it? Usually the surgical fees could pay for a lot of consultations.

The second thing is more education of staff members. These courses we are conducting for general practitioners in all societies, national as well as local and state, are all aiming at that. More consultations, continuing the education of the doctor. Those are the two things.
MR. CUNNINGHAM: Where is the impetus to come from for these things?

MAC F. CAHAL is secretary and general counsel of the American College of Radiology. A recognized authority on medico-legal problems, Mr. Cahal has also served as executive secretary of a state medical society and business manager of a foundation devoted to medical education and research and hospitals.

Who is going to move toward establishing more consultations? Are the standardizing bodies?

DR. BROWN: It is coming from two places. That is one of them and the other one is right in the hospital. It is happening more and more and more. Many times I have heard some young man say, "I called in so and so. This poor patient didn't have a dime. He gave me a fine consultation and didn't charge the patient anything." I suppose this sort of thing will have to come through the standardizing bodies before it goes all over. It is a round robin. It is a matter of education, more education and reeducation.

MR. CAHAL: I think Dr. Moore touched upon an important point, economics. The cost of medicine increases because medicine can do more. It costs more to treat a case of pneumonia today than it did 50 years ago. As for the economics of compulsory consultation, I see no reason why the suggestion should not be made that the surgeon pay the consultant out of his fee. That is not splitting fees as long as the patient knows about it. Splitting fees is taboo only when it is not known by the patient.

DR. MOORE: Well, you could get around it in another way, as they're now doing in some of our hospitals where a patient comes in for a group examination. Maybe three or four doctors will see the patient—the nose and throat man, say, the eye man, an internist and a surgeon. The patient pays the hospital a low flat rate for the entire examination and the fee is distributed equitably among the four men.

MR. CAHAL: That is all right if the hospital doesn't keep a little nibble of profit for itself.

DR. BROWN: You had better explain that statement. I am a hospital administrator. I am ready to hop on you.

MR. CAHAL: I will, because those things are being done in some hospitals. In some hospitals it is a standardized diagnostic procedure for a flat fee to be charged, yet the entire fee does not go to the doctor who renders the examination.

MR. CUNNINGHAM: But the hospital has an overhead.

DR. BROWN: Who is going to pay for the overhead?

MR. CAHAL: Why, the patient ought to pay for it.

DR. BROWN: How?

MR. CAHAL: You ought to have two fees. I am utterly, violently, unequivocally opposed to the hospital charging a fee and acting as a middleman, keeping out a portion of the fee and paying the balance over to the doctors.

MR. CUNNINGHAM: The complication of having two fees to pay is one of the things that is keeping these plans from becoming more widely used.

DR. MOORE: On the other hand, you can put it this way, that if the patient is seen in the hospital and the doctors use hospital facilities, I don't see why part of that fee should not be given for the use of the hospital.

MR. CAHAL: That is quite reasonable but look at the practical situation. The fact is that two members of this team are too often salaried employes of the hospital already, the radiologist and the pathologist. If the hospital collects a fee for this diagnostic service, it is profiting.

DR. MOORE: I am used to having the hospital profit off me for my years in pathology. If it didn't I wouldn't have any job. Years ago the hospital had to have a profit because the first laboratories that were started went in the red.

MR. CUNNINGHAM: You had no acceptance. You were fighting an uphill battle.

DR. MOORE: The doctor in those days opposed the patient's paying for laboratory work. In fact, he didn't want any done. He could tell what was wrong. He could tell whether the person had kidney disease without a urinalysis. He knew whether they were anemic. He looked at their tongue.

DR. BROWN: In my short lifetime I have seen the doctor who took hemoglobin tests by looking at my tongue and putting blood on a piece of paper.

MR. CUNNINGHAM: It is done today. That is one of the really sad things, that for all the improved knowledge and improved technics in all the things that you do, there are still probably more of them done by the piece of paper.

MR. CAHAL: There is a profit motive in that, too. The doctor charges for that.

MR. CUNNINGHAM: I would be inclined to think it was more inertia than profit.

DR. MOORE: I think so in the majority of cases. But getting back to our consultation and how it would be taken care of. The question is, are we going to have state medicine or is the medical profession going to give it to the people in the right way? My idea is that we are going to give it to them better than state medicine. We can handle it ourselves, and we can give it to them at a reasonable fee, and we are going to do that with our state medical society plans that we now have, like hospitalization insurance.

MR. CUNNINGHAM: This man up in Milwaukee has proposed an organized consultation service which the hospital would pay for, I believe.

MR. CAHAL: How can it?

MR. CUNNINGHAM: He proposed that the hospital finance the thing, organize and finance it.

MR. CAHAL: Where is it going to get the money?

MR. CUNNINGHAM: From the patients. Possibly the economics of it were not clearly worked out, but unless the financing of it is arranged, unless somebody is thinking about that, it just isn't going to happen.

MR. CAHAL: I agree with that. You have got to be practical.

MR. CUNNINGHAM: I think the economic barrier to consultation is an important barrier.

DR. MOORE: Let's take one disease on which we are having consultations. We have approved tumor clinics all over the United States. I am connected here in Chicago with two of them. All the patients who are seen there in that tumor clinic pay practically nothing and none of the consultants get anything for their service.

MR. CUNNINGHAM: If enough of that is going to be done you have got to get paid.

DR. MOORE: We are compensated in seeing that the cancer patient gets better care and earlier care, and we will

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instill in the physician a pride in having better care for the cancer patient. After a while we will get paid, but in the meantime we are not losing. The profession is gaining tremendously by it.

MR. CAHAL: Within the last twenty years, I think, medicine has awakened to the profound importance of pathology and yet every economic study of physicians' incomes shows the pathologist at the very bottom of the list.

DR. BROWN: Well I would like to put in a word for the hospital administrator.

DR. MOORE: You are right there. If I sympathize with anybody it is with the hospital administrator and the hospital medical director, too. I was offered a job as medical director of a hospital, and I said, "I am having enough trouble as a pathologist."

DR. BROWN: Some hospitals don't want a real administrator. They want anything but an administrator. They want somebody that can be led around with a ring in his nose.

MR. CAHAL: Is that true?

DR. BROWN: I don't say it is widely true, but there are instances. That is part of the picture. So these hospital administrative schools which are growing rapidly are going to make a mark on this world, and they are going to help this medical care picture get better.

DR. MOORE: They are going to help. The medical staff is supreme in the hospital on medical affairs. When you get your hospital administration classes trained all over the country they are going out to run hospitals the way real hospital administrators think they should be run and they are going to break their necks on staff after staff. I have seen many hospital directors go out and have the right ideas and then write to me after six months, "It is just impossible. I can't get the staff to see it." That is going on all over the country.

DR. BROWN: But about the third time over it begins to take hold.

DR. MOORE: I don't get pessimistic at all. Sometimes I regret that I can't live long enough to put all these things through that I want to, but somebody else will put them through.

MR. CUNNINGHAM: Now, that is a fine, forward looking, hopeful note to end on!

A.H.A. Convention: St. Louis

FOUR broad fields of discussion will be featured at the 49th annual convention of the American Hospital Association in St. Louis September 22 to 25, it is indicated in the advance program released from association headquarters in Chicago. The four main divisions are: professional practice, administrative practice, hospital planning and special problems.

The convention, which is expected to bring 7000 hospital people to St. Louis, will open with a general session in the municipal auditorium opera house Monday afternoon, September 22. Theme of this meeting is "Factors Affecting the Hospital Economy," and the principal attraction will be a talk on public interest in hospital financing by Kay Kyser, band leader and movie actor, who has been actively interested in the hospital and health planning movement in North Carolina, his native state.

After the opening assembly, the convention will split into its four subdivisions for successive sessions Tuesday morning and afternoon, Wednesday morning and afternoon and Thursday morning. In final assembly Thursday afternoon, leaders of these sub-groups will present summaries of their deliberations under the general title, "American Hospitals Today."

Raising standards of medical practice in the hospital will be the subject of three full sessions of the professional practice group, according to the program. The first of these meetings will focus attention on problems peculiar to the large hospital, taking up such angles as qualification and classification of staff members, limiting staff privileges and rights of the general practitioner.

Medical standards in the small hospital will be dealt with at the next professional practice meeting, with emphasis on pathology service, consultations and the point rating system developed recently by the American College of Surgeons. A third session, summarizing the discussions on medical standards, will seek to define the responsibilities of the governing board for medical quality.

The remaining meetings of the professional practice group will hear discussions of nursing and nursing education and outpatient services. Featured on the professional programs will be such authorities as Dr. R. C. Buerki of Philadelphia, chairman of the association's professional practice council, and Dr. Frank C. Sutton of Rochester General Hospital, Rochester, N. Y.

Headlining the administrative practice sessions will be the Tuesday morning meeting on "Establishing Contract Rates"—a title which may be swiftly translated to read, "How much money from Blue Cross?" Various speakers will work over the comparative advantages of charges and costs as the basis for hospital reimbursement, "negotiated community rates" and the point system now used in parts of Canada.

Other sessions of the administrative practice group will treat such subjects as employment practices, trustee relations, purchasing and hospital costs.

Operation of the hospital construction act, maintenance problems and planning units for psychiatric and chronic patients will be the main themes of the hospital planning and plant operation sessions, which will be led by Dr. Albert Snoke, council chairman. The fourth large group will deal with special aspects of the hospital field.

Travel Is So Broadening

"Cook's tours" of the hospital give employes an insight into the background of the institution and widen their understanding and appreciation of the other fellow's problems

MABEL W. BINNER
Administrator, Children's Memorial Hospital, Chicago

YEARS before the term "public relations" was used in connection with hospitals, we conducted tours through Children's Memorial Hospital, Chicago, which, with apologies to the well known travel bureau, have been known to our personnel as "Cook's tours."

1. We meet in the board room for a brief talk.

While tours have been conducted for neighborhood groups, church societies, clubs, new volunteers and new members of the board of trustees, the tour and introductory remarks for each are planned somewhat differently, as certain points require greater emphasis in one case than they do in another.

The most important group, however, is the one made up of the hospital personnel. If members of your staff do not know the background of the hospital, know only the little section within which they operate, you can not expect intelligent cooperation from them. It is a waste of time, money and effort to tell the public what you are doing (or hope you are doing) until you have put some time and effort into educating your own staff.

About two weeks before a series of tours is scheduled the heads of departments are advised regarding these dates and are asked to submit names of recently employed members of their staffs, stating their preferences as to days. As groups are limited to 15 persons, time is allowed for rechecking with department heads, should the list submitted for any one day exceed that number.

The tour requires approximately two hours. There is no segregation as to departments. It is important that all meet on an equal plane, professional and nonprofessional, in order that class barriers be broken down. We meet in the board room for a ten or fifteen minute talk before starting on the tour. Emphasis is placed upon the need for the services of all, our dependence upon one another, our one common reason for being here, namely, the patient. The following points are covered:

1. Founding of the hospital.
2. Brief history of development.
3. Present organization: Lines of authority, from trustees to administrator, to head of department, to each employe. (Each department is listed on a blackboard.)
4. Support of hospital.
5. Policies—how and why made.
6. Services offered by hospital.

2. On to the laundry for a demonstration.

7. Special needs in a children's hospital.

8. Community relationships.

9. Responsibility to and cooperation with some 20 or more approving, regulating, licensing organizations and others of that type, as: American College of Surgeons, American Medical Association, state department of registration and education, health department—state and local—police department, fire department and underwriters.

Use is made of pictures, blackboard and a large drawing of the entire plant, showing the location of all nine buildings. Opportunity is allowed for questions. The plan of the tour is explained, as obviously we cannot cover all parts of the hospital within the brief period allowed. If anyone is especially interested in some department not included in the tour, he is encouraged to say so. He will then have the opportunity to see that section or department at the close of the regular tour, or at a later date.

5

5. How the x-ray department aids in diagnoses.

4

4. Medical records are extremely important.

The administrative offices are shown; a demonstration is planned by laundry personnel; we visit the outpatient department, social service department, medical record library, x-ray department, endoscopic operating room, kitchens, school of nursing classrooms and demonstration rooms and several of the wards. Comment is made as we go from one department to another regarding anything of interest. Too technical explanations are avoided; human interest stories, those with either pathos or humor, help keep the group interested and in good spirits.

During the war we were forced to abandon the tours. When we resumed these recently I was surprised to see some of our long term employes in the groups. I questioned one: "Surely, Mary, you have been around on the tour before?" She replied: "Yes, but you know I enjoyed it so much I wanted to go again, it makes me feel that I am doing something worth while."

We listen to the psychologists expound on this subject, we read much that is written, but we are too likely to overlook the simple methods right at hand to give the employe that feeling of importance that is so necessary to her best interests and ours.

3

3. Stopover in the endoscopic surgery.

THE DAY HOSPITAL

An Experimental Form of Hospitalization for Psychiatric Patients

D. EWEN CAMERON, M.D.
Allan Memorial Institute of Psychiatry
Montreal, Que.

A NEW form of hospitalization has been set up on an experimental basis in the Allan Memorial Institute of Psychiatry, Montreal, Que., and has been in operation since April 1946. It has been evolved out of an arrangement of psychosociological and economic factors which differs in certain important respects from that found in the customary types of hospitalization.

Those who have had the job of organizing departments of psychiatry in general hospitals have commonly planned them in a way which as closely as possible resembles that in which the other departments of the hospital are organized. This is in part an expression of the policy of breaking down in the minds of the hospital staff, of the patients and of their relatives the concept that psychiatric illness is different from all other forms of illness. In part it arises from the vaguely thought out conviction that the ways of administering hospital care which have been so successful in the general hospital will serve to raise the standards of efficiency when transferred to the department of psychiatry.

Not All Have Validity

A number of the methods and ideas that psychiatric departments have taken over from other departments of the general hospital have most assuredly proved themselves useful and productive. But we have also taken over some methods and ideas which, while they have validity in many of the divisions of the general hospital, have none in the psychiatric department. Indeed, in many instances they constitute an actual handicap to us.

Among those which clearly are useful throughout all departments of the hospital are the intern system and the consultation service. Among those which are well entrenched in the other departments, such as surgery, internal medicine and gynecology, but which have little or no validity when transferred to the psychiatric department, are the concepts that: (1) a hospital is a place where the patient goes to bed; (2) a hospital is a place where a patient stays until he is well, or as well as the doctor can make him, and (3) a hospital is a place where only the patient is treated.

Having recognized these factors, we have begun to experiment with new kinds of hospital settings in which to furnish psychiatric treatment more effectively. The particular form which I wish to describe is the Day Hospital. This unit gives expression to the facts that psychiatric patients do not need to stay in bed; that they do not have to remain in hospital until they are well and, indeed, often do not get well if we try to make them stay, and that it is not only the patient but also his family unit and his general social setting which require to be treated.

Patients come to the Day Hospital at 9:00 a.m. and remain throughout the daylight hours, receiving the appropriate forms of treatment. At 4:30 p.m. they begin to go home and the ward is closed at 5:30 p.m.

All types of patients are admitted, the only criterion being that they should be well enough to stay at home overnight. Some idea of the range of such patients is afforded by considering the number of persons who, in these days of overcrowded hospitals, have to remain on the waiting list—and therefore at home—for many months.

An appreciable proportion of our patients suffer from early forms, or relatively mild advanced types, of schizophrenia. Both hypomanic and depressive patients have been successfully treated in the Day Hospital. We carry in the Day Hospital, as does everyone who has an office practice, patients who are hallucinating and patients who have been expressing suicidal ideas.

Must Assess Patients' Problems

In deciding whether or not to admit such patients to the Day Hospital or to the rest of the hospital, we have to weigh their assets: how well they are socialized, how well they are integrated into their family group and the reliability of that group. We have to assess, of course, our psychoneurotic patients in precisely the same way. We have had at least as much difficulty in managing severe psychoneurotic reactions in the Day Hospital as we have had in dealing with psychotic individuals.

On occasion, patients originally admitted to the Day Hospital have had to be transferred to the day and night division of the institute. Typical situations which have led to transfer are illustrated in the following four consecutive instances:

The first patient's condition deteriorated rapidly during the first three or four days after admission. She became so antisocial and disorganized that she no longer fitted into the setting. The second said that she felt that the difficulties which she

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had with her husband when she went home quite offset the gains she had made during the day and she requested twenty-four hour hospitalization. The third, who was suffering from a degree of mucous colitis, found it hard to remain on a strict diet at home. The fourth woman, suffering from anxiety and severe repressed hostility, became, during the course of psychotherapy, so aware of her hostility toward her mother, with whom she was living, that it was felt wiser that she should remain in hospital while this aspect of her therapy was going forward.

From this it will be understood that the Day Hospital should be thought of as extending and supplementing the work of the day and night hospital. It may be that, for certain categories of patients at least, it will eventually take its place, but at present the Day Hospital should be operated in association with a day and night hospital.

In practice, we have found that those patients who are first admitted to the ordinary day and night division of the institute and then transferred to the Day Hospital make a somewhat better adjustment than do those who are admitted directly to the Day Hospital. Patients in the first group tend to feel that their transfer to the Day Hospital indicates progress; moreover, by this time they have established relations with the institute staff and are accustomed to the technical procedures.

It Didn't Seem Like a Hospital

Some of those who were admitted directly from their homes to the Day Hospital encountered some difficulties in terms of their stereotypes of what hospitals should be like. One or two of them felt that because they did not go to bed, and because they went home at night, they were not receiving hospital care. This attitude, however, can be offset in a large measure by careful planning of the patient's first day in hospital, ensuring that the nature of his experience is explained to him and also that he has an opportunity within the first few hours to obtain some of the things which he had anticipated he would receive, among these being an opportunity to state his problem in as great detail as possible to a member of the psychiatric staff.

At first, all patients admitted to the unit were women, but later, after we had established the Day Hospital principle on the men's ward, we brought men and women patients together for certain therapies, such as group psychotherapy and occupational therapy. Two hundred and nineteen patients were treated during the first twelve months. The duration of a stay was about five weeks.

Table 1—Origin and Disposal of Patients in Day Hospital

ORIGIN		DISPOSAL	
Direct admissions	105	Home	164
From rest of institute	105	Institute (day and night)	34
From general wards, R.V.H.	5	Wards of R.V.H.	3
Readmissions	4	Died	1
		Committed	1
		Remaining in Day Hospital	16
	219		219

NOTE: The number transferred from the Day Hospital to the rest of the institute is high because of policy of admitting a certain number of patients to the Day Hospital for work-up prior to admission to the rest of the institute.

Table 2—Forms of Therapy Used in Day Hospital

Individual psychotherapy	E.C.T. (low voltage, unidirectional)
Group psychotherapy	E.C.T. (alternating current)
Occupational therapy	Narcoanalysis
Weight-raising insulin	Conditioned reflex treatment of alcoholism
Somnolent insulin	Endocrine and vitamin therapies
Coma insulin	
Adrenalin desensitization	

The origin and disposal of these patients will be seen from table 1. The kinds of treatment which can be furnished within this setting are shown in table 2. Some of these treatments required special modification in view of the fact that we do not observe these patients over a twenty-four hour period. In particular, insulin coma therapy was modified to the extent that the insulin was administered intravenously and the onset of coma was hastened by the addition of sodium amytal.

Efforts were made to limit the amount of confusion and memory disturbance arising in consequence of the electroconvulsive therapy by using the unidirectional type of apparatus and by work carried out by Dr. J. Beaubien and Dr. J. S. Tyhurst upon the use of vasodilators. We may say that confusion in Day Hospital patients undergoing electroconvulsive therapy has disappeared as a problem.

One of the major advantages of this type of hospitalization is that the patients do not have the complete break with their homes that takes place when they enter a day and night hospital. Thus, the therapist, the patient and the home remain much closer, and the patient and therapist can work in a setting much more akin to that to which he must finally be adjusted than is the case when the patient is removed entirely out of his everyday situation.

Provides Suitable Setting

In consequence, we have found that the Day Hospital setting has been most suitable for the carrying out of our plans to develop more adequate psychodynamics and psychotherapeutic concepts. It is commonly agreed that many of those in current use, while therapeutically fruitful, do not lend themselves to experimental verification. It is also agreed that many of the ways of conceptualizing human behavior employed by the social sciences are readily adaptable to experimental validation but do not so easily lend themselves to therapeutic use.

Accordingly, we have been actively engaged in exploring new ways of conceptualizing both directive and nondirective therapy, with respect

alike to their therapeutic value and to their amenability to research methods.

In all this, our work has been rendered more vital, the issues have been made more living and pressing, by reason of the fact that the patient remains in daily, in realistic, relation with the problems of his home and his general social setting. This new design has enabled us to obviate the "escape into hospital," the retreat into the private room, the regressive surrender to all pervasive direction, that surrender which is only too willingly made by people who want to give up and be told.

Treatment of the family is provided not only through the social service department but through the setting up of a "relatives' discussion therapy group."

Morale Is High

It is noteworthy that the morale of the Day Hospital is definitely higher than that of the rest of the institute, even though the latter is an entirely open hospital, *i.e.* there exist no means whatsoever of keeping patients once they wish to leave. Thus, although admission and stay in the institute are entirely voluntary, the Day Hospital has apparently the additional advantage that to go home each night and to return each morning seems to act as a daily reaffirmation of the fact that the patient is there on a voluntary basis.

Friction among patients and antagonisms expressed by the patients toward the staff are kept at a low level. The duration of hospital stay is usually shorter and the final readjustment to the home at the end of therapy is considerably easier, the patient facing the termination of hospital stay without the anxieties, doubts and insecurities which often appear in those patients whose contact with the home has been broken by admission to the day and night hospital.

At the outset it was found that the saving in space from not having to provide overnight bed space or storage space for patients' clothing and belongings allowed us to take care of twice as many patients as would be possible in the same area in the usual day and night hospital.

For the 20 bed unit we provide a supervisory nurse, one graduate, one or two student nurses, an occupational therapist and a part time social worker. One shift of nurses is required in place of the usual three. The unit makes use of the intern, psychological, biochemical, electrophysiological, administrative and secretarial resources of the institute.

At this point I should like to stress the fact that a great deal depends upon the ability of the supervisory nurse to create the most nearly adequate psychological climate in the Day Hospital.

In regard to costs, it can be said that, at the outset, in view of the fact that we put twice as many patients in the same floor space, we undertook to cut by half the rates charged elsewhere in the institute. Hence, our public ward patients pay $3 per day, our semiprivate patients, $4 and our private patients, $5. The city has agreed to recompense us for the care of indigent patients on the same basis as we are recompensed for patients elsewhere in the institute, and we are at present negotiating with the Blue Cross to accept this plan of hospitalization.

Figures for twelve months' operation indicate that we were able to operate at a per capita per diem cost of $2.16. During that year we rendered approximately 5000 patient days' care, the Day Hospital being closed on Sundays.

It is our impression that this form of hospitalization can be extended not only within psychiatry but also into other departments of medicine. There seems no reason, for instance, why it should not be applied to certain categories of patients within the departments of internal medicine and gynecology. It could certainly be applied in the new convalescent, rehabilitation and resocialization units which are planned for addition to some of the leading hospital centers.

Finally, I may say that we consider that this is only one of many new kinds of setting that may be devised to supplement, and perhaps to replace, the older forms of immurement in the general hospital.

Demand Is Increasing

Many factors are conspiring to increase the demand on the part of the public for hospitalization. Among these is the progressive loss on the part of the family of its former capacity to care for its sick members, owing to the smaller size of the family unit and the fact that the women members are, to a greater extent, becoming employed outside the home. Another general factor is the necessity for expensive equipment and highly trained staff, which can be most expeditiously centralized at the hospital. A third factor is that, to an increasing degree, medical care is now administered by a team rather than by an individual.

It is becoming clear that no building program, however ambitious, can hope to meet the great demands which have already been made, and the still greater demands which will be made, for treatment in hospital. If, however, we take as our guiding principle that, as far as is possible, treatment should be provided *at* the hospital rather than *in* the hospital, we can reasonably expect a series of adaptations and inventions, such as the one outlined in this paper, which will permit all hospital centers to give intensive medical care to considerable numbers of patients without the necessity of providing the most expensive form of hospitalization, namely, "in-bed" care.

Care of the Long Term Patient Requires Careful Planning

DAVID LITTAUER, M.D.
Administrator, Menorah Hospital, Kansas City, Mo.

IT IS now generally recognized that the long term medical or surgical patient is best cared for in the general hospital where there are diversified skills and therapeutic facilities necessary to treat the patient as a whole clinical being and not merely in terms of his major complaint. Many hospitals, spurred by surveys made by social and health agencies which point up the inadequacy of provisions for care and treatment of the chronically ill in their communities, are therefore debating the addition to their physical plants of facilities for this group of patients.

Despite this healthy interest in a phase of medical science which has been too long neglected, there is evidence that the implications of embarking on a program of care for the chronically ill in the general hospital have not been grasped completely by great numbers in the hospital community, nor the public at large.

Even the basic concept of what constitutes the chronic disease patient is not always clearly understood. Is he the custodial patient with the burned-out hemiplegia, who needs but the care of the practical nurse? The medical scientist and the expensive and intricate equipment of the general hospital are not required for him. Is he the convalescent, recovering from a serious illness or major operation? His is primarily a problem of rehabilitation, frequently short-lived, and making small demands on the specialized skills and facilities that make up the modern hospital.

The true chronic disease patient, however, knows no age group, nor is he limited by classification of disease. He may be a child suffering from severe diabetes mellitus which requires months of study before it can be regulated; or an elderly woman suffering from deforming arthritis which slowly responds to the persevering efforts of the internist, the orthopedist and the doctor of physical medicine; or an unfortunate in the terminal stages of inoperable cancer, requiring extensive nursing care and frequent medication; or a young man with an early tuberculous lesion which will be rendered inactive after several months of intensive therapy. He is, in short, the patient suffering from a long term illness who will benefit from hospital care.

Auxiliary Services and Departments

The modern hospital is equipped to deal with the specific medical and surgical phases of a patient's illness, whether acute or chronic. Additional services should be planned for the latter group, however, if these patients are to obtain maximum benefit from their treatment in the hospital and if they are to return to the maximum participation in home and community activity consistent with their physical condition. Such services include the following:

Social Service Department. The patient suffering from a chronic disease is no stranger to the hospital; usually he has had several previous periods of hospitalization. There has been a progressive loss in his ability to be a self supporting member of the community. Unless he has an independent income, his ability to pay his way in the hospital is seriously curtailed.

There may be strained family ties. The children resent the constant financial drain of an ailing parent; the brothers and sisters shrug off their sibling; the parent resents the chronically ill child he has sired. After the patient's admission to the hospital, his family, mistaking chronic disease care for custodial care, has moved to a smaller home. The decompensated cardiac patient, ready for discharge, must be relocated in a first floor apartment so that he need not walk up three flights of stairs to his present place of abode.

Such situations are commonplace in the care of the long term patient. For proper solution they require a well staffed and well trained social service department, familiar with family case work as well as with medical social work. If provision is not made for adequate social service, the administrator will find that the patient's recovery will be impeded because social problems have not been solved, and his discharge will be delayed because the home whence he came is not suitable or no longer exists.

Physical Therapy Department. Certain groups of long term patients, particularly those suffering from arthritis, spastic or flaccid paralysis or surgical conditions of the bones, joints and muscles, require extensive therapy by physical means.

This implies a more elaborate department than is normally required in the acute general hospital. A small gymnasium must be provided. In addition to the arm and leg whirlpools and the Hubbard tank, hydrotherapy must include a walk-about pool, with its movable hand rails and crane and sling.

Physical therapy for the convalescent recovering from an acute illness or operation is normally short-lived and simple and is directed by the registered physical therapist on the prescription of the attending physician or surgeon. The long term patient, however, is frequently a baffling clinical problem. In such cases the medical scientist must seek the advice of a specialist in the modalities of physical therapy who also knows the physiology and pathology of the condition to be treated. Somewhere along the line of planning, therefore, a decision may have to be made in favor of a doctor of physical medicine over a registered technician.

Recreation

The long term patient spends only a short time every day, or every other day, in the portion of the hospital devoted to the medical services. Following the intensive work-up on admission, he will spend from twenty-two to twenty-four hours daily, for weeks on end, surveying the same scene from his hospital bed, unless he is busied with activities at the bedside or elsewhere in the hospital. Ideally, these would include:

Patients' Library of several thousand volumes: The library may be brought to the patient by book cart, but it is preferable to have the walk-in type to which the ambulant or wheelchair patient can repair to make a personal selection of his books.

Motion Picture Theater: With the "movies" such an accepted pattern of our daily lives, great pleasure can be brought to the hospital shut-in by having this form of recreation available to him. The small screen placed at one end of the day room or ward, or the film flashed on the ceiling, is not as satisfactory as are the surroundings in which the patient has been accustomed to see films in the past. The theater which has wide spaces between rows and a section in the rear containing no seats, so that wheel chairs and even beds can be brought into position, is the one of choice.

Occupational Therapy: This department should be large enough to offer a variety of types of work to the long term patient, whether he can come to the workroom or is confined to his bed. Looming of rugs, working with leather, bookbinding, painting, carpentry and woodworking are activities which can occupy a patient's time, enable him to create something useful and in many instances serve as therapeutic devices to exercise atrophied or spastic muscles and stiffened joints. In larger hospitals an occupational therapy department could be combined with physical therapy into one department of rehabilitation.

Follow-Up Clinic

The acutely ill patient, on recovering from his pneumonia or his appendectomy, is no longer a clinical problem. The chronic sufferer still has his defective heart or malfunctioning kidneys; if after care is neglected he will again become a hospital case in short order. Hence a follow-up clinic for those patients who suffer from long term ailments and who cannot afford private medical care is a vital part of a chronic disease program.

Professional Care

It will be necessary to prepare the resident staff, and usually the visiting staff as well, for the change in pace of diagnosis and treatment which the long term patient introduces. This applies particularly to the hospital with a charity or teaching service. The intern or resident, accustomed to a rapid turnover of acute cases, may feel that he is deprived of essential training if the same patient occupies the same bed for weeks or months at a time. The visiting physician or surgeon can no longer point with pride to his hospital as having the lowest average patient day stay in the community.

Such problems can be anticipated and met by extending the existing visiting and house staff departmental organization to include the long term patients. Such a functional grouping will provide the visiting physician or surgeon with the admixture of acutely and chronically ill patients he encounters in his private practice. It will also provide an adequate reservoir of training for the medical or surgical resident. And soon both visiting and house staffs will realize that the long term patient, far from being a deterrent to training, is usually a baffling clinical problem and a challenge to the best medical skills.

The care of long term patients is more satisfactory to patient and to hospital alike if it is carried on in nursing units which are structurally and functionally organized for the purpose.

Rooms or wards in the long term nursing unit should have ample closet or locker space, a day room which can do duty as a dining room for the semiambulant and alcoves for the large numbers of wheel chairs and stretcher carts that will be required. Horizontal construction with access to the grounds is preferable to vertical construction. If the hospital has limited grounds, a roof deck should be made available to the patient who must otherwise spend weeks or months within doors.

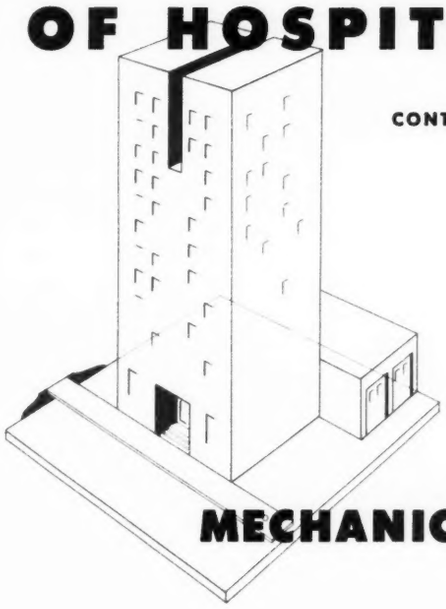
Chronically ill patients should also be grouped together for purposes of nursing care. It will usually be found that economy of graduate nurses will be achieved, since more auxiliary workers can be utilized. At the same time the nursing personnel of the unit, whether graduate, undergraduate or auxiliary, can develop their own procedures affecting nursing care of the chronic sufferer—routine inspection for incipient bed sores or treatment of bed sores which have already developed; scrupulous attention to intake and output and to bowel hygiene.

The Cost of Care

It has been mentioned previously that the chronically ill patient is only too often a medical indigent. His own and his family's resources may have been exhausted. He may have used up the benefits of hospital insurance, or may be too old to qualify for such insurance. The community may not hold itself responsible for utilizing public funds for the care of an indigent patient in a voluntary hospital.

The cost of patient care is constantly increasing. Even allowing for a lower cost for long term patients, an operating cost of $3000 per bed per year for the average long term patient is not unreasonably high in many communities. The hospital administrator and his board should know whether public or private funds will be available for the maintenance of the long term patient before they commit their hospital to this hitherto neglected phase of hospital service.

THE FUNCTIONAL BASIS OF HOSPITAL PLANNING



MECHANICAL SECTION

CONTINUING A STUDY BY THE DIVISION OF HOSPITAL FACILITIES

UNITED STATES PUBLIC HEALTH SERVICE

THE FIRST COST OF THE MECHANICAL and electrical equipment of a hospital is approximately one third of the total cost of the building. Moreover, the cost of operating and maintaining this equipment is far greater than it is for all other parts of the building. Special consideration should therefore be given to the design and selection of materials for the mechanical and electrical plant so that the first cost can be reduced, unnecessary repairs can be eliminated and the cost of labor, fuel and power can be reduced to the minimum. At the same time the plant must be adequate to protect the health and safety of patients and employes and to maintain sanitary conditions in the hospital.

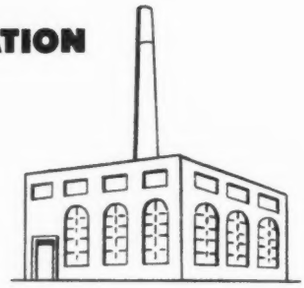
These objectives can only be accomplished by simplifying the design, by using systems of proved merit and by employing only the best materials and equipment. Not only is an overly elaborate plant expensive to install but the increased cost of operation and maintenance is an annual charge for the life of the building.

Since the operation of a hospital is dependent upon a good water supply, sewage disposal and electric service, special consideration should be given to these services in selecting a hospital site. The state or local health department and the mechanical engineer should be consulted before a site is chosen.

The architect, hospital staff and hospital consultant plan the various departments of the hospital and specify the clinical equipment required by the doctors, technicians and nurses. However, it is the responsibility of the consulting engineer to provide heating, sanitary and electrical systems that will guarantee the proper functioning of these departments and their equipment, temperatures best suited for the patients, sanitary conditions and efficient operation of the hospital. It is therefore of the utmost importance that consulting engineers be selected who are acquainted with hospital practice, who are competent to design the systems involved and who have no interest in sales or contracting.

It is not the intent of these recommendations to cover engineering fundamentals or problems common to building construction, but rather to present special phases which are peculiar to hospitals and of interest to the hospital architect and engineer.

HEATING, STEAM SUPPLY AND VENTILATION



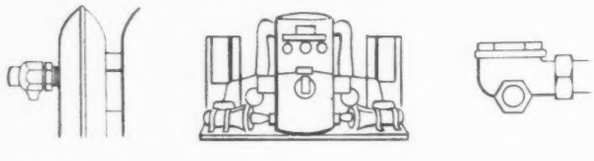
THE HEATING, STEAM SUPPLY AND VENTILATING SYSTEMS are closely related to each other, both in physical installation and in their functional relationship to the various departments of the hospital. These relationships must be kept in mind when the systems are planned.

HEATING AND STEAM SUPPLY

HEATING SYSTEMS. The heating system should be designed to maintain a constant temperature of from 70 to 72° F. in the bedrooms, corridors and service areas. Where a higher temperature is desirable for a patient, this can be provided by the use of additional blankets. It is not practical to design a heating system for a higher temperature and reduce bedroom temperatures by regulating valves. The temperatures in operating rooms, recovery rooms, nurseries, delivery rooms and similar spaces should be 80° F. but the additional heat required to maintain this temperature can be supplied by auxiliary radiation connected to the high pressure steam system or to the plumbing hot water system.

This arrangement provides normal temperatures except when the higher temperatures are required, as during operations, and makes it possible to provide heat when the regular heating system is shut down, as in the spring and early fall. Laundries, kitchens and sterilizing rooms require little heat because they are often overheated by their equipment. Toilet temperatures should not be over 68° F. while bathrooms may require 80° F. Storage rooms for anesthetic gases should not be heated.

Some architects and engineers believe that the constant uniform temperature required in most areas of the hospital can best be maintained at the lowest operating cost, without noise, by the use of a forced hot water heating system. Where steam heating systems are used they should be of the vapor modulating orifice type with automatic controls which will maintain constant temperature with some heat in the radiators at all times. Vapor systems of heating require more maintenance than do hot water systems as the life of traps is limited, uniform control is more difficult and noises may develop.



Where the walls are well insulated, the size of the radiators and heating boilers can be reduced by approximately 25 per cent. If, in addition to the wall insulation, the windows are double glazed with a sealed air space between the panes, the size of the radiators and heating boiler can be reduced by 50 per cent. Such insulation should be considered, especially for buildings in climates where the temperature reaches 0° F. and in areas where the cost of fuel is relatively high, as it increases comfort and reduces operating costs. In cold climates double glass in windows is advisable where high humidities are required, as in operating rooms. Insulation will also reduce the cost of air conditioning in areas of the country where air conditioning is necessary.

PRELIMINARY PLANNING. During the preliminary planning, the approximate size of the boilers and boiler room equipment must be determined so that the necessary space can be allotted for boiler and pump rooms. Chases and furred spaces should also be provided for heating risers, swing connections to radiators and steam piping. Spandrel and other beams should be set to clear riser chases and furrings should be arranged to leave free space for expansion and insulation. It is not advisable to use floor fill for radiator branches or other pipes. These requirements should be discussed in detail with the architect, plumbing engineer and structural engineers to avoid interference.

BOILERS. The necessary boiler capacity can be roughly estimated on the basis of one boiler h.p. per bed, where the heat is figured for 0° F. For a 100 bed hospital, 100 boiler h.p. will supply heat for the hospital and steam for laundry, kitchen and sterilizers. To this must be added reserve capacity in case of boiler failure, because it is essential that the plant shall function continuously even under the most adverse conditions. The heating load in 0° F. weather will be approximately two thirds of the total.

Thus, if two 100 h.p. boilers were used to generate heat and steam and provide breakdown service for a 100 bed hospital, it would be necessary to operate during the summer months at less than one third rated capacity. For a hospital of this size a 70 h.p. steel hot water boiler and two 40 h.p. 125 pound boilers will, under most conditions, meet all require-

ments, save the cost of 50 boiler h.p. and operate more efficiently.

The first cost of a hot water heating boiler is less than that of a high pressure boiler and the maintenance charges are less as it will not corrode, requires no pumps and can be operated without a licensed engineer. As the hot water heating boiler can be reconditioned during the summer months, a breakdown should not be anticipated; this contingency can be taken care of by operating the two steam boilers at 125 per cent rating and using a hot water converter for the heating system.

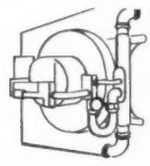
Should high pressure steam boilers be used for heating, three boilers of equal size are preferable to two. Heat requirements may be roughly estimated from a ratio of 1 square foot of radiation to 80 cubic feet of space. To this heating load must be added 25 per cent for pipe and boiler losses and the steam requirements for laundry, hot water, kitchen and sterilizers.

In smaller hospitals, it is advisable to provide a small high pressure water tube boiler which will carry the high pressure steam load on holidays and at night when the laundry is not in operation. Most codes permit the operation of 10 h.p. boilers at 200 per cent rating without a licensed engineer. With oil, gas or stokers, such boilers can be connected for full automatic operation.

Centrifugal or rotary type of boiler feed water pumps with steam turbines should be considered, as the exhaust steam from reciprocating steam pumps carries some oil through the separators to the boiler, where it forms scale. Where exhaust steam from reciprocating engines or pumps is used, steam separators and water filters are advisable to protect the boilers. Separate return tanks are recommended for the low pressure and high pressure systems where an open type of feed water heater is not used. Vents from these tanks can be run through a cold water coil to conserve the steam that might otherwise escape.

Where the use of electric power is economical motor driven pumps are recommended for the small plants, although one steam turbine driven pump should be provided in case of power failure. These pumps should be equipped with automatic controls, feed water heaters and boiler feed regulators. Exhaust steam from turbines should be utilized for heating hot water. Automatic soot blowers are recommended to increase efficiency and reduce labor. To guarantee continuous steam service to the hospital, a ring-header should be considered for the boiler, with two high pressure mains, either of which can be used for sterilizers and kitchens.

Oil or gas fired boilers should be used unless the cost of these fuels exceeds the combined cost of coal and labor because they eliminate the noise and dirt caused by coal and ash handling. Number 6 or bunker "C" oil can be burned satisfactorily with properly designed burners which operate with a high-low flame and automatic control on the air supply.



Gas burners should be of an approved automatic type. If coal is used automatic stokers are more economical than hand firing, as a lower grade coal can be used and a saving can be made in labor. Where electrically driven oil burners, blowers or stokers are used connections must be made to a reliable emergency electric service.

In the smaller hospitals, boiler rooms can be installed and operated more economically in the building. Water tube boilers are preferred by many engineers because they operate efficiently at overloads and are not considered a hazard. Portable firebox water tube boilers are available which occupy little space and head room and operate efficiently. Boiler rooms should be separated from other parts of the building by fireproof walls and fire underwriters' doors with exits from two points and ample window area. Space must be provided for the removal of boiler tubes, and openings through which boilers can be removed are often found necessary. Ceilings should be insulated.

For the larger institution, a separate building near the hospital for the boilers and laundry is advisable. Steam and water piping from the boiler house should be run in a tunnel which may also serve as a passage for laundry trucks. Boilers must be set higher for oil burners and stokers than is necessary for hand firing. Thus, when hand firing is used, it is well to provide head room for the maximum height setting to permit a change to other methods if desired later on.

If future expansion of the hospital is possible, it should be provided for either through extra boiler capacity (if expansion is imminent) or by arranging space for additional boilers. Recording steam gauges, recording CO_2 meters, recording steam meters, flue gas thermometers and indicating draught gauges promote efficiency. Boiler compounds will be required where hard water or water from zeolite softeners is used, but care must be exercised in selecting the proper treatment.

Steam Requirements. The steam requirements for sterilizers and kitchens can be estimated from the table on page 68. However, it must be borne in mind that all equipment will not be operating at one time and that heat losses from the supply and return piping must be added.

HOURLY STEAM CONSUMPTION

EQUIPMENT	HOURLY RATES
14 by 22 inch Pressure dressing sterilizer	16 Pounds
16 by 36 inch Pressure dressing sterilizer	30 Pounds
20 by 36 inch Pressure dressing sterilizer	43 Pounds
12 by 20 inch Pressure instrument sterilizer	20 Pounds
16 by 24 inch Pressure instrument sterilizer	29 Pounds
15 by 24 inch Pressure laboratory sterilizer	16 Pounds
21 by 30 inch Pressure laboratory sterilizer	27 Pounds
10 gallon Water sterilizer—one reservoir	60 Pounds
54 Bottle capacity sterilizer	34 Pounds
9 by 10 by 20 inch Boiling sterilizers	20 Pounds
12 by 16 by 24 inch Boiling sterilizers	40 Pounds
24 by 24 inch 3-compartment kitchen steamer	75 Pounds
40 gallon—Kitchen kettle	37 Pounds
30 inch Bain Marie per foot in length	12.5 Pounds
60 inch Steam table	25 Pounds

The average laundry should require approximately ¼ h.p. boiler capacity per patient. Steam must also be furnished to heat approximately 5 gallons of water per hour per patient for general use in the hospital.

Piping. Steam piping should be provided to supply 100 pounds' pressure at the laundry, 40 pounds to sterilizers, 20 pounds for kitchens and 2 pounds to kitchen steamers. Low pressure steam at 5 pounds' pressure is recommended for hot water heating inasmuch as the water temperatures can be controlled more accurately.

Where steam is used for heating and the steam is thermostatically controlled, orifices should be used at all radiator supply valves to guarantee an even distribution of steam to all radiators. An overhead hot water heating main, where ceiling space is available, has the advantage that radiators can be vented through the risers to the overhead expansion tank instead of by individual vent valves. Steam and hot water pipes 2 inches and larger should preferably be welded, with long radius bends for hot water piping.

Standard weight steel or wrought iron pipe can be used for hot water and low pressure steam piping, but extra heavy steel or wrought iron pipe should be used for high pressure piping, returns and trap discharge lines. Steam pattern cast-iron fittings are satisfactory for the smaller pipes.

Steam and condensation flowing in opposite directions in the same pipe are responsible for most cases of water hammer. This can be eliminated by drips, properly located on all steam mains and branches, or by larger pipes. To ensure efficient and noiseless operation, each piece of equipment should have a separate trap of the proper size and design to remove all air and condensation rapidly. Where large pressure-reducing valves are required, it is advisable to provide two valves in parallel to supply varying loads without noise and wire drawing.

Relief valves will protect equipment and controls on the low pressure side. Manually controlled valves should be used on radiators, and hot water radiators should have one key-operated valve which can be set permanently to adjust the flow of water through the radiator and used to stop the flow in case of leaks. Each riser, each branch main and each piece of equipment should be valved separately to permit repair and replacement.

Traps, pressure reducing valves, regulating valves and similar equipment should have 3-valve bypasses and strainers. High pressure boilers should be connected and valved in accordance with the state boiler code. Insulated valve handles should be used on globe valves at equipment. Strainers in steam connections at pressure sterilizers will protect the controls and prolong the life of the steam filters.

Radiators. Inasmuch as the heating engineer is responsible for the maintenance of satisfactory temperatures, he should consider in detail the wall and roof construction and particularly the window leakage which may be anticipated.

The size of hot water radiators need not be larger than those of a vapor system, when an average water temperature of 215° F. is used. With forced hot water circulation, the branches, mains and risers may be even smaller than those of a steam system. Exposed cast-iron or convector types of radiators are preferable to concealed radiators because they can be cleaned more readily, reduce air movement and provide some

radiant heat. Radiators should be wall hung and connections should be made to the wall rather than to the floor to facilitate cleaning. Special cast-iron hospital radiators are not required, as standard ones can be satisfactorily cleaned with brushes.

Where there are two windows in a bedroom it is not advisable to place a radiator under the window nearest the bed. This tends to overheat the patient and is an unnecessary expense. Neither is it necessary to set a radiator under each window of other rooms. Concealed radiators are recommended for operating rooms and delivery rooms, but special hinged panels should be provided for cleaning.

Radiant Heating. Properly designed radiant heating systems, using low temperature hot water, have been considered favorably for hospitals. However, their cost, with special plaster and construction, is higher than that of conventional systems. Should radiant heating be used, it is best to select an engineer with experience in the design of such systems. Heating coils for the panels may be located in the plaster or in the floor slab. The structural engineer should be consulted if the coils are to be poured into the floor slab, and high floor temperatures should be avoided. Many building codes prohibit the use of coils in the structural slab. If the coils are located in floors, the floor covering must be considered, while if they are in the plaster, streaks may be expected on the ceiling.

Such systems, however, have many advantages. The objectionable radiators are eliminated, and a more comfortable condition is provided at a lower temperature. Radiant heating can be used effectively to heat the patient by radiation from the ceiling even with the windows open. It is also an ideal system for mental hospitals and nurseries, where radiators and grilles should not be exposed.

Thermostatic Control. It is not practicable to maintain constant temperatures by manual control of the flow of steam to the radiators because this requires constant supervision by the engineer or nurses. Control by a thermostat in each room is expensive and has not proved entirely satisfactory in hospitals. Zone or sectional thermostatic controls are considered preferable, with north and south exposures separately controlled. The east exposure can usually be controlled with the south section, and the west with the north. Thermostatic controls which are actuated by outside temperature, wind velocity and an inside pilot thermometer have given good service.

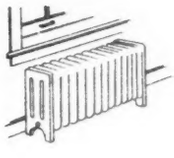
In hot water heating systems, the water at the boiler or converter should be held at a constant temperature. The temperature of the circulating water can be varied with a thermostatically controlled three-way valve which will bypass return water and mix it with the high temperature water to give the required temperature. The modulating type of control with orifices is preferable for low pressure steam systems, inasmuch as it is considered desirable to retain some heat in the radiators.

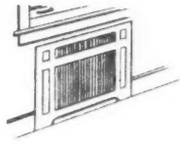
RELATED INSTALLATIONS

Fuel Storage. The size of coal storage bins and fuel oil storage tanks should be governed by the facilities available for deliveries. In most cases, when deliveries are dependable, the coal bins should be of ample size to store one month's supply plus a freight car load. Two oil tanks are advisable when delivery services are not dependable, each of proper size to receive a full tank truck load. Delivery chutes, ash hoists and fill lines should be located so that the noise of trucks will not disturb the patients.

Incinerators. Garbage and refuse incinerators are usually required and should be made a part of the boiler room. These should be designed to burn at least 50 per cent wet garbage, which requires high temperatures and ample combustion space. The garbage room and charging hopper should be above the incinerator, but not at an elevation which might cause back draughts. The furnace, combustion chamber and flue should be lined with high temperature A-1 fire brick and tile. The flue should have a damper. The boiler smoke stack may be used for the incinerator, but the stack capacity must be increased for the additional load.

In or adjoining the garbage room there should be a can-washing pan with hot and cold water sprays and a steam sterilizer. Incinerators should preferably have gas or oil burners to maintain high temperatures. Grates in the rear section of the boilers have been used as destructors. Garbage destructors or grinders, connected with the street sewers, have proved satisfactory where their use is permitted. These can be





set under the scraping sinks of the dishwashing table to receive the garbage directly through a screen.

SPRINKLERS. Automatic sprinkler systems installed separately or as a part of the heating system should be considered for storerooms, kitchens, dining rooms,

laboratories, shops, trash rooms and spaces which are not regularly occupied. The saving in the fire insurance rate will usually balance the expenditure, although the safety of the patients and the building is sufficient justification in itself. The National Board of Fire Underwriters has regulations governing different types of systems and providing varying reductions in rates. These should be consulted when possible.

VENTILATION

GENERAL. The ventilation of hospitals should be limited to minimum requirements as determined by health, comfort and safety standards. The air should be changed in spaces in which excessive heat is generated, where objectionable odors are present and where explosive gases might accumulate. For work spaces in the smaller hospitals, exhaust ventilation will suffice. Air leakage will replace the quantities exhausted for most such areas and the introduction of air from windows will not be objectionable for overheated spaces.

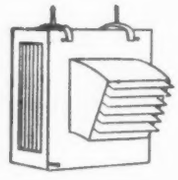
Air supply systems are required for operating rooms and nurseries. Should an air supply system be desirable for other spaces, the quantity of air supplied should be less than that exhausted so that odors will not be forced into other hospital departments. Separate ventilating systems should be provided for departments which have different working hours to reduce operating costs. The minimum requirements of some areas may be covered by state codes. For the larger exhaust systems, and where ventilation is essential, it is advisable to install two fans, each of which carries half the full load. One fan can be used for breakdown service and to reduce the air exhausted when the full amount is not required.

KITCHENS. The ventilating system for kitchens should be designed to remove the heat, vapor and odors from the cooking, dishwashing and serving areas. Special attention must be given to the cooking space with the ranges, broilers, ovens, kettles and steamers.

Preparation spaces that have windows need not be ventilated separately. The cooking, dishwashing and serving areas in the kitchen and cafeteria should have hoods, with the bottom edge approximately 6 feet 6 inches from the floor. It is also advisable to provide exhaust registers in or near the ceiling to remove hot air and vapor which are not exhausted by the hoods. The ducts from the ranges should be constructed of heavy gauge metal properly insulated to resist grease fires. Copper ducts are preferable for exhausting such vapors as those from dishwashers.

Both the cooking and dishwasher area ducts must be constructed with watertight bottoms, and vertical sections should be so assembled that condensation will drain to one or more drip pipes. High pressure steam lines should be connected into ducts and hoods of ranges to smother grease fires. Kitchen exhaust systems should discharge above the roof. Range hoods should be constructed with smooth surfaces to permit easy cleaning.

LAUNDRY. The primary purpose of the ventilating system for the laundry is to remove vapor and heated air from the ironer, presses and washers. At least 50 per cent of the air should be taken from a hood over the ironer. The quantity exhausted varies with the size of the machines and the natural ventilation of the room. For a 100 bed hospital, the exhaust re-

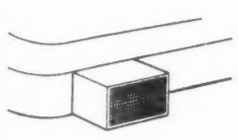


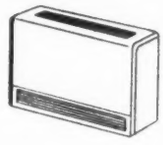
quired from the ironer is approximately 2500 cubic feet per minute. This air should be taken from a hood with hinged glass panels mounted directly over the ironer. An additional exhaust, equipped with a lint catcher, must be connected with the tumbler to carry the air from the fan to the roof.

OPERATING AND DELIVERY ROOMS. Operating rooms, delivery rooms and adjacent corridors require special consideration. In addition to the grounding of floors to prevent static sparks (to be described in the electrical section), ventilation is necessary in these spaces to reduce the concentration of explosive gases and to raise the humidity, which reduces static. The ventilation system should change the air from eight to 12 times per hour, and the air conditioning system should maintain a relative humidity of at least 55 per cent. The air must be filtered and introduced into these spaces without appreciable air movement. The exhaust should be taken from a point near the floor to remove dust and the heavier gases. The heat gener-

ated in sterilizing rooms adjoining operating and delivery rooms should be removed by fans.

Many hospitals cool the operating and delivery rooms when outside temperatures are high. Extreme temperature differentials and drafts should be avoided, and the system must be designed to use 100 per cent fresh air. Recovery rooms will require cooling where they are used with conditioned operating





rooms. All rooms that require air conditioning should be furnished with accurate instruments to indicate the relative humidity and temperature.

Nurseries. Nurseries require higher temperatures and humidities than do other sections of the hospital. The air supply should be filtered without recirculation and introduced in such a way that there will be no drafts. Nurseries for normal babies should be conditioned to maintain a temperature of 75° F. and a relative humidity of 55 per cent. The temperature requirements of premature infants vary widely, necessitating the use of separate incubators for the weaker infants. However, a nursery temperature of 75° F. with 65 per cent relative humidity has been found satisfactory for the majority of premature infants.

Laboratories. Laboratory hoods must be connected with vent lines through the roof and acid resisting fans and vent pipe should be used. For such vents it is preferable to place the fan on the roof to prevent the possibility of acid fumes being forced into the building. The treatment of animal rooms depends on the animals used. In all cases these rooms must be ventilated to prevent odors from reaching hospital rooms.

Laboratories that will work with virus materials require ventilation to safeguard the technicians and prevent cross-contamination and spread of the virus. These laboratories must have no open windows and so must be completely air-conditioned. A negative pressure is maintained in the laboratories to prevent the spread of contaminated air to sterile areas. Germicidal lamps are also used in the laboratory work areas.

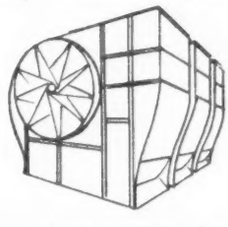
Exhaust air should be taken from a slot or similar opening just above the work counters and from the hoods. The exhaust from the hoods in which active virus is used must be effectively sterilized to eliminate the danger of contaminating areas near the laboratory. Gas and electric heaters designed to heat the exhausted air to 600° F. have proved effective. The exhaust from animal rooms and work spaces is treated with ultraviolet germicidal rays.

Allergies. The treatment of allergy patients requires air at a constant temperature and free from dust, fungi and pollen. Air filters will remove the larger particles of dust, but electrical precipitation is necessary for the smaller pollen and dust particles. Humidifiers should be provided to maintain a relative humidity of from 35 to 50 per cent with a temperature of 72° F. Ventilating units with filters and humidification will serve where central ventilation systems are not feasible. Portable electrical filters have been manufactured for individual rooms and can be used if precautions are taken to prevent sparks from igniting oxygen or other explosive gases.

Odors. Any rooms and spaces in which odors may be generated, such as morgues and animal houses, should be exhausted by separate systems which will discharge above the roof or well away from any windows. The odors carried by exhaust air can be reduced by the introduction of ozone at the exhaust outlet.

Gases. Rooms and spaces in which explosive gases are stored or used should be ventilated to reduce the concentration from leakage or use below the explosion level. Gravity supply and exhaust ventilation is preferable for storage rooms inasmuch as mechanical ventilation would have little supervision.

Miscellaneous Requirements. All exhaust ventilation should be carried to the roof or well away from windows. Where high humidities are required in cold climates, double window glass should be used to prevent condensation. Inside rooms which may be used as work spaces should be ventilated. Inside toilets, baths, bedpan rooms or alcoves and sterilizer



rooms require ventilation. The larger toilets, baths and showers which have three or more units usually require ventilation regardless of their location. However, small toilets, baths, diet kitchens in which little cooking is done and utility rooms of nursing units do not require ventilation if they have windows.

All closets should have louvers, grilles or openings to ensure ample circulation of air. The large central sterilizer rooms and enclosures for sterilizers require ventilation, but in most cases gravity ventilation will suffice. Spaces under doors or louvers are required for rooms from which air is exhausted. Vertical

louvers should not be used for exhaust outlets as wind pressure is often greater than the air pressure created by the fan.

GENERAL CONSIDERATIONS

Noise. The mechanical plant is responsible for many of the objectionable noises encountered in hospitals. Motor noises are usually due to alternating current; the high frequency hum can often be eliminated only by replacing the motor. However, this and most mechanical noises can be controlled by separating the equipment from the building structure with sound insulating materials. Heavy reciprocating machines can be insulated by using heavy concrete bases set on a bed of sand and insulated from the floor with cork.

Valve noises are sometimes transmitted by pipes, in which cases special hose or soft copper tubing may isolate the sound. Water hammer in pipes can be prevented by properly located traps. Steam noises can be avoided by using low steam velocities.

Operating and Maintenance Instructions. Plans that show the correct location of all mains, risers, connections, valves and equipment should be prepared and filed for reference. Numbered brass tags should be permanently attached to valve handles and a valve schedule should be prepared and framed under glass to show the location and purpose of each valve. For proper maintenance an indexed manual should be compiled for each piece of equipment, containing the necessary operating instructions and all pertinent manufacturer's literature. A schedule giving the interval at which each piece of equipment should be inspected, cleaned, serviced and oiled, with spaces for the dates when the work is done, will reduce maintenance chores and the cost of repairs.

Guides. For details of current practices in heating, ventilating and air conditioning, the engineering papers and "Guide" of the American Society of Heating and Ventilating Engineers and the regulations of the Heating, Piping and Air Conditioning Contractors' Association should be consulted.

SECTIONS ON MECHANICAL DEPARTMENTS

Following an article next month on functional planning of such optional hospital facilities as the outpatient department and dental clinic, the remaining sections in the Division of Hospital Facilities text will appear in succeeding months in the Plant Operation and Maintenance Department. These articles will cover plumbing, electrical equipment, elevators, kitchens, refrigeration, laundries and maintenance shops.

Two Sides to the Question of Nurse Education

1—CONDENSE THE CURRICULUM

The two year basic course should include the essentials required to make a good bedside nurse and supply a firm foundation for those who wish further training

SISTER ROSA
St. Joseph's Central House, Emmitsburg, Md.

WHEN life is at stake, should traditions hold us shackled? There is a growing current of thought, evolving from the nursing crisis, that in the systematizing of our nursing schools a two year basic course should be considered. The proposal seems radical—so radical that those who entertain it still hide it covertly in a corner. The old tradition of a three year course is grounded deep in our hospital consciousness. Even three years seems inadequate for all that must be taught.

In my work with general, mental and other types of hospitals, and in the associations, East and West, which that work has brought, I am often asked my opinion of nursing schools, the essentials of curriculums, the changes that are needed to cope with the changing times. At the risk of being called radical, I am going to state truthfully and openly that I agree with those who whisper that a two year basic course in nursing would go far toward solving the nursing problem.

There Are Many Reasons

Why do I believe this and urge that the two year course be sincerely considered?

1. We must have more nurses and we must have them speedily. We know the consequences of our nursing shortage: the closing of small hospitals and locking the wings of large ones; inadequate care of the sick; periods of illness lengthened; permanent impairment of individual health; jeopardizing of national health; even the loss of lives.

2. Nurses lament heavy hours, drudgery, long apprenticeship, inadequate compensation. In this they deserve just consideration. And because of this, the profession has lost prestige. It no longer has the glow of patriotism or the aura of romance. It is a consecrated service, but its beauty is shrouded in the gray veils of burdensome labor, exacting study, overpowering fatigue.

3. We all lament and wax eloquent over the incompetency of nursing service. Instead of criticizing and uselessly berating, as we have done for many years, let us seize this after-the-war opportunity and use our power of organization to systematize and standardize our nursing schools, revise them according to a graded plan, throw out the nonessentials of basic training, compress the essentials into intelligence and efficiency, put emphasis on competent bedside nursing, leave the college courses and degrees to those who have the ambition to climb higher in the profession and speedily solve our nursing problem before more harm is done.

Have we not long heard that the whole subject of nursing education needs revision? Has it not often been said that the theoretical education given the student is more than is required to make a competent bedside nurse? Do not the majority of doctors and administrators agree to this? Then, why not get something done?

In the April 1947 issue of *Hospitals,* Dr. Frederick Carter of St. Luke's Hospital, Cleveland, stated

"Because our methods have not been *concise,* there has been a great deal of fumbling and wasted effort. . . . In some instances we are training people for the lifelong practice of a profession or vocation. In other instances we must train people largely so that they may be efficient workers while they are part of our organization.

"In many situations a hit-or-miss apprentice system has prevailed. Much apprentice time has been wasted because of poor planning. . . . Our pursuit of efficiency in nursing education will be fruitless until we identify and correct conditions that are responsible for young women failing to enter our schools and for graduates abandoning their profession."

What I personally urge is such a carefully worked out system of training that it would *compress* in a two year course those essentials which would produce an excellent bedside nurse, at the same time supplying a firm foundation which would enable the nurse to climb higher into the specialized plane should she elect to do so. "The vast majority of nurses marry young."

Try to Teach Too Much

It is my opinion that we try to teach too much in our present basic curriculum; we give a smattering of everything and leave thoroughness outside the window. In meeting the requirements for many subjects, in goading students to pass their finals, we forget a more important adage: *The patient is all; all things for the patient.*

But please do not misunderstand me. I do not for a moment suggest that we lower our ideals or eject the fundamentals. Neither do I say that all nursing schools are inefficient, but I do say that all could be more efficient.

What I emphasize is this: Why not give a *good* bedside nurse to the patient? That is what the patient wants. Then let the seeker after higher training go forth to the schools of higher education, to the colleges and universities. But give us—give us as quickly and efficiently as possible—the genuine, kindly,

cheerful, patient-loving nurse; not the one who has lost her enthusiasm.

There is another reason why I favor a two year basic course, a course which would be so compact and efficiently conducted that it would merit state certification for its students. We have heard over and over again, and we know it to be true, that many nurses leave the profession for more attractive fields. This, I think, is not due entirely to the fact that other professions are more attractive. It is also due to the changing channels of thought which naturally occur as youth traverses the adolescent period.

The high school graduate on Graduation Day is fired with the spirit of service. Every graduation speaker holds forth to her the ideal of dedication and helpfulness to others. Instinctively, the 18 year old feels that she cannot find happiness unless she lavishes kindness upon others. She wants to pour out her heart in comfort and compassion for those who suffer. This is the propitious time for a young woman to enter the nursing profession.

So, take this high school graduate with her high aspirations. Teach her the love of the patient while she is in this formative stage, when she is idealistic for service and finds happiness in caring for others.

College Student Less Idealistic

The college graduate is more mature. She is rightly dwelling on the thought of marriage. Between her present ways of thinking and her thoughts of four years before there is a great difference. Perhaps she has grown weary and captious from the grind of excessive study. Perhaps a spirit of cynicism has warped her ideals. Whatever may be her attitude, we know that the college graduate *versus* the high school graduate has less of the plastic dream-stuff that can be molded into devotion to others.

Nursing, too, we are told by every nurse and administrator, must be a personal service, a service to the individual patient. This must always remain the central concept of nursing education. But how shall we indelibly impress this personal service to the patient upon the nurse unless we take the young girl just out of high school or two years of college and develop her innate craving to minister unto others, giving the student nurse thorough training in bedside care; drilling her in the nursing arts under the direct supervision of the nursing arts instructor of the nursing school, not depending for this on the floor supervisor who already has too much to do?

Surely, our insistence on cramming a heavy three year course of study into the mind of a growing, active girl who has already gone through twelve years of schooling has much to do with the scarcity of nursing applications which we so much bemoan. Surely, any active girl, if tied down too long to books, will lose the ardor of those pent-up energies; the ideal of service will be diminished; something of indifference and a "why-bother" attitude will intrude.

I speak of the average girl whose name is legion. There are other individuals, beyond the average, who aspire higher. Let them go on to the higher levels of nursing education; to the college and university courses; to their postgraduate work and degrees.

We need them, too. We need them vitally for our supervisory, instructional and administrative positions. We need them for our veterans' hospitals and Red Cross; for our Bureau of Indian Affairs and foreign research; for our executive positions with national, state, county and local nursing groups; our industrial and missionary nursing; our special fields of medical, surgical, pediatric, obstetric and orthopedic nursing; for our psychiatric, tuberculosis and cancer hospitals. Yes, there is room for all; far too much room; far too much need in proportion to our supply.

I should like to point here to a resolution adopted by the American Medical Association in 1848, and irrevocably maintained, which I think we should have in mind as we set about perfecting our nursing education. The resolution reads:

"Resolved, that this Association consider defective and erroneous every system of medical instruction which does not rest on the basis of practical demonstration and clinical teaching; and that it is, therefore, the duty of the medical schools to resort to every honorable means to gain access for their students to the wards of a well regulated hospital."

In our tendency to incline more to theory, may we not guard our limits by this warning from our doctors, for nursing, like medicine, cannot be learned from books or lectures alone, but chiefly from observation of the sick and intensive experience in bedside care.

In considering the perfecting of our nursing courses I am also of the opinion that there should be only *one kind of nurse*—the professional nurse; with no less than a high school education, or two years of college; trained carefully in the basic course and any other higher levels she chooses to elect; registered by the state. I agree that the title "nurse" should be reserved exclusively for the skilled group known as registered nurses. Between the professional nurse and all other types of aides and attendants, I think the line of demarcation should be as clear as that between a doctor and an orderly.

There Would Be More Nurses

If we can train a practical nurse in one year, why not add the extra year of the pruned and accelerated curriculum which would make her a registered nurse with no less than a high school education? This will be strengthening the standards of the nursing profession; it will increase the ambition of young girls to acquire a high school education; it will greatly augment the number of registered nurses in whom the patient can have full confidence.

In the discussion of different levels of training and salaries for nurses, it will be argued that in actual hospital service it would be difficult to allocate their duties harmoniously, and that in emergencies there would be confusion and dissension.

Without suggesting that our nurses be regimented, may I point to a comparison? Our soldiers made up of different levels of rank—privates, corporals, sergeants, captains, colonels—have won all our wars with foreign powers. Why cannot our nurses, also graded and marshaled by rank, just as effectively win our wars with disease? The grading of nurses would also combat the criticism of young graduates that hospital nursing offers no future because good work is seldom recognized either by promotion or by increase in salary.

What difficulty would there be, for example, in allocating to a higher place and rewarding with a higher salary the nurse who has specialized

in psychiatry, with an intensive course after her state registration, even though she chooses to serve in a general hospital rather than a mental institution? Are there no patients in the general hospital needing her knowledge and special skill in psychiatry? Is it not merely a matter of assignment to change her from one duty to another?

In openly advocating a two year basic course as one means of solving a critical problem, I should also like to mention the benefits that would accrue if we brought something of the nursing profession directly into the high school, through the medium of a course in home nursing in connection with the home economics department. The goal in this case should be the future home life of the girl and the lessening of family trials, expenses and worries. Here would be opportunity to hold forth the advantage of later more intensive training in nursing, not only as a means of service but as a means of livelihood in numerous careers.

Recently I saw a lobby placard which read: "Nursing—the Gateway to a Thousand Careers." That may have been exaggerated, but consider the limitless number of fields to which training in nursing is actually a gateway. How the horizon widens as health becomes the national and world focus!

I cannot refrain from mentioning here the solemn warning of Pope Pius XII in a reference to world peace, wherein he declared that security cannot have any other solid foundation than the *physical* and moral well being of a nation, based internally on right public order and externally on normal relations with other states. May we not look upon the nurse and the doctor as the focal centers of the physical well being of our nation, and must we not admit that the hospital administrator has a large share of responsibility in contributing to that physical well being?

In this regard, in aiming for more nurses, thousands of more nurses, let us take a long range view: the beneficial effects in producing good wives and good mothers; healthy, wholesome children; a better citizenry; a better nation. Do not nurses make the best mothers? Can we think of a former nurse keeping a squalid, unkempt house? Does not nursing bring out all that is wholesome, orderly and appealing in a woman?

The hour is here for action. Let us act swiftly, as America acted after Pearl Harbor. Another war is on—a war against sickness, disability and chronic illness. Let us take our raw material, accelerate its fashioning and send our white-uniformed soldiers into the field.

2—EXPAND THE CURRICULUM

Preparation for nursing should include training in a medical center in the various specialties and experience in a rural or semi-urban hospital and health agency

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THE wide variation in the quality of nursing service in this country is accounted for, in part, by extreme variations in the quality of preparation that nurses receive. One obvious attack on the problem of providing improved service to patients in hospitals and public health agencies is a marked improvement in or the discontinuance of schools of nursing which are now giving inadequate preparation to their students.

Prominent on the list of inadequacies with which many graduate nurses are charged are: the inability to cope with complicated problems of patients who are receiving highly specialized care, with complex equipment, in large medical centers; the inability of a high proportion of nurses to sense the satisfactions of nursing patients in rural and semi-urban institutions and agencies, and the inability to care for mental patients and patients with tuberculosis and communicable diseases.

Other failures that have been noted include the inability of nurses to serve on the research team; to do health teaching; to include preventive aspects of nursing care in hospitals, and to function as first level public health nurses in public health agencies, without additional preparation, and, finally, the inability of many nurses to serve as effective, informed citizens participating in community activities.

These inadequacies in nurses are traceable to poor preparation. Preparation for nursing is lacking in that, in many schools, situations such as the following are found:

Students do not have an opportunity to learn how to care for a diversity of patients requiring highly technical nursing. Schools in many small hospitals have neither the type of patients nor the complex equipment which all graduate professional nurses should know how to handle. For example, students do not have the opportunities for nursing communicable disease and tuberculous patients or those with mental diseases.

Students do not have the opportunity to participate in nursing care of high standard. They have no exposure to the satisfactions of practice in semi-urban and rural communities. Community functions of hospitals and experience in community nursing are not included in the curriculum. In addition, instruction is given by many poorly qualified instructors who are also suffering from the handicap of these same inadequacies.

I believe all hospitals and health agencies and, most especially, all patients would benefit if every professional nurse received the following preparation: training in medicine, surgery and related specialties, in pediatrics and obstetrics in a large medical center where the standard of care given is high; experience in a rural or semi-urban hospital and health agency where high standards

are maintained; experience in psychiatry, tuberculosis and, if possible, other communicable diseases.

She should also have experience, or its equivalent through integrated instruction, in the elements of preventive medicine and public health nursing and should be taught by well qualified instructors, who have special preparation for the field in which they teach.

For these reasons, I believe that nursing schools should have a direct connection with large medical centers and with an educational institution. All students should practice for a period of approximately six months in a small community hospital health center. Instruction in the sciences and other subjects should be centralized for two or more nursing schools in an educational institution, a university or a college, with nurse supervision and integration of instruction.

Fewer Schools Needed

A much smaller number of schools than at present could prepare the full quota of professional nurses needed in this country. Suppose, instead of 1300 schools of nursing, which we have at present, many of them very poor, we had 500 schools admitting an average of 80 students annually. Graduations should then be approximately 30,000 annually, which would maintain the present supply of professional nurses. The average size of school enrollment would be about 210.

In the typical school, at any one time, one sixth of these students, or 35, would be enrolled in the college or university (six months' preclinical period). One sixth, another 35, would be having experience at rural or semi-urban hospitals and health centers; one twelfth, or about 17, at a psychiatric institution; one twelfth, or about 18, in a special hospital for communicable disease, tuberculosis and a public health agency when available; one half, or 105, of the total enrollment would be practicing at the large medical center.

If two small hospitals served as clinical fields for this school, each would have 17 or 18 students. A thousand such small hospitals and health centers would be included in the plan in addition to the 500 large medical centers.

The school would provide all instruction, including that most important type, clinical instruction, for its students, wherever they were assigned for experience. For the rural hospital one or two part time clinical instructors would be required, depending upon the services offered. One instructor could supervise experience in medical and surgical nursing; there would be an additional part time clinical instructor if obstetric experience was included.

Would Rotate Instructors

These qualified supervisors could be rotated periodically, if it seemed desirable, from the medical center to the rural community to assure a constant supply of qualified nurses for this purpose and to integrate knowledge of rural community problems into the general instruction given students at the medical center.

The rotating supervisors would also provide excellent supervision of nursing service in the smaller hospitals. The presence of properly selected students with some experience in the larger centers and the qualified instructors would stimulate improvements in service in the small hospital. The system would obviate the necessity for the maintenance of a full faculty, as is now the case in many small hospital schools which have poorly selected students and poor faculty and which supply many of our inadequately prepared nurses. Nursing service standards in the large medical center would be under constant review and would also be maintained at a high level.

This system could be financed in part by income from student service. Tuition fees would cover the charges for instruction at the college or university for the first six months. Medical centers, psychiatric institutions, special hospitals, rural or semi-urban hospitals and health centers would each pay an amount equivalent to the value of student services into the school budget.

Payment of fractions of salaries of all part time clinical instructors and full salaries for full time instructors would be made from this income. It would provide all educational facilities. If the income from student services did not cover all costs, endowment or tax funds (local or state) would be necessary to supplement the school budget.

For some hospitals now conducting schools of nursing, this system would be more economical than is their present arrangement. For all hospitals, with or without schools, special or general, large or small, and for all patients, this system would assure better care of patients.

The total number of instructional personnel required for these students would be smaller than the present number, which is impossible to procure from the existing professional group of graduate nurses.

Recruitment would be easier because the quality of all schools would be high. Intrinsic appeals would be attractive. All patients cared for by graduates of such schools would receive care which included psychosomatic and preventive aspects. Nurses would be prepared for specialties that are now understaffed. More graduate nurses would choose positions in rural and semi-urban hospitals. Improved distribution of nursing services by a professional group of the present size would require additional supplementary, nonprofessional services—this, in itself, being desirable.

More intelligent planning would result in wiser nurse utilization, which is imperative when we consider the woman power of the nation. Communities would understand the functions and values of the professional school and its support—a community responsibility now "hidden" in the general misconception of the interrelationship of nursing schools and hospitals.

System Is Flexible

This system is flexible enough to allow the development of units of a size varying from the example used here. Figures on size of hospitals and on school enrollment lead me to believe that this system, which reverses our present system of affiliation management, is possible. Cost figures may (though not, certainly, at this writing) demonstrate the economy of such a system.

The two major premises on which this plan is built are these: (1) Schools of nursing must meet their obligation to prepare nurses for total community needs. The community, from the nursing point of view, is not limited by city, county or state boundaries but is national. The needs are not limited to hospitals. (2) Hospitals must meet their obligation to budget for paid nursing service that is adequate in quality and quantity.

ART for the Patient's Sake

Are you considering a division of medical illustration? Duke Hospital has helpful suggestions that are based on sixteen years' experience in a previously uncharted field

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ENCOURAGED by the success with which such plans have met in some of the larger teaching hospitals, many administrators are now considering the incorporation of a division of medical illustration in their own plants. What can they reasonably expect from such a step? How is such a division organized and maintained? How great will be the expenditure in such an operation? And, above all, what return will be realized through investing in an illustration division?

In sixteen years of experience, the medical illustration division of Duke Hospital and Medical School has undergone a complete metamorphosis. We have emerged from a one medical artist and one part time medical photographer setup to a division of medical illustration composed of a staff of nine housed in a seven room suite. In this time we have accumulated a great deal of experience that might be useful to one who is planning to follow this previously uncharted program.

We have been kindly referred to as "one of the most complete and well organized divisions of its kind in American schools" and, inasmuch as we receive a number of letters of inquiry, perhaps the best way of imparting the information we have assimilated "the hard way" would be to describe the progress of our own experience and to give a concrete plan for organizing a division similar to ours.

In the first place, satisfactory administration of such a division is dependent upon three major factors: (1) an adequate independent budget, (2) an active illustration committee and (3) thoroughly trained personnel. An independent budget allows work to be undertaken on requisition signed by the head of a division, and no charge is made either to staff members or to departments. This encourages investigators to write papers, illustrate lectures, write books, present exhibits and to use more methods of visual education, thus enhancing the hospital's reputation. The lack of an independent budget tends to discourage adequate illustration of all types of publications.

An illustration committee is necessary to act as a buffer between the staff and the head of the medical illustration division, to be responsible for the finances and to act as general advisers in regard to policy. It is most important that this committee be composed of staff members who are interested in medical visual education problems. The head of the division is therefore directly responsible only to the illustration committee. All problems that cannot be solved by the head of the division can be referred to the illustration committee for consideration and direct action. Thoroughly trained personel is essential in order to carry through efficiently and expertly the policies established by the illustration committee.

In the broad sense, the medical illustration division will handle many more duties than are generally ascribed to an artistic staff. The primary function of the division is, of course, to prepare all illustrative material for teaching and publication. The clinical photographic side of the division will be easily appreciated. Our doctors have repeatedly expressed appreciation for the supplementation of case histories by exact photographs indicating the beginning, progress and conclusion of a medical history. A complete file of these and all other illustrative material will be kept for the convenience of staff members for teaching and planning illustrations for lectures and manuscripts.

The preparation of casts and models for teaching lies also within the province of the illustration division. A museum or demonstration room should also be a divisional service. The care of all film projectors will be the responsibility of the division, as will the production of motion pictures and lantern slides needed in the hospital. In addition, a service afforded by the medical illustration division that is often overlooked is the aid it renders in many of the allied fields. Our work in anatomical prosthetics, epidermal injections and opaque cosmetic applications is a vital operation.

As to the physical aspects of the division, the following are preferred as ideal basic requirements: one large photographic studio, about the size of two standard hospital rooms; one large darkroom which can be subdivided if necessary; one general workroom and office, and one large airy, day lighted room for the art studio. Other offices and supplementary space can be added as required.

All rooms should be either interconnecting or grouped for maximum efficiency with a minimum of waste motion required in passing from one to the other. They should be located as near to operating rooms and clinics as is feasible. This will facilitate the transportation of patients and equipment to and from the division.

The basic equipment for a well rounded division of medical illustration should include the following:

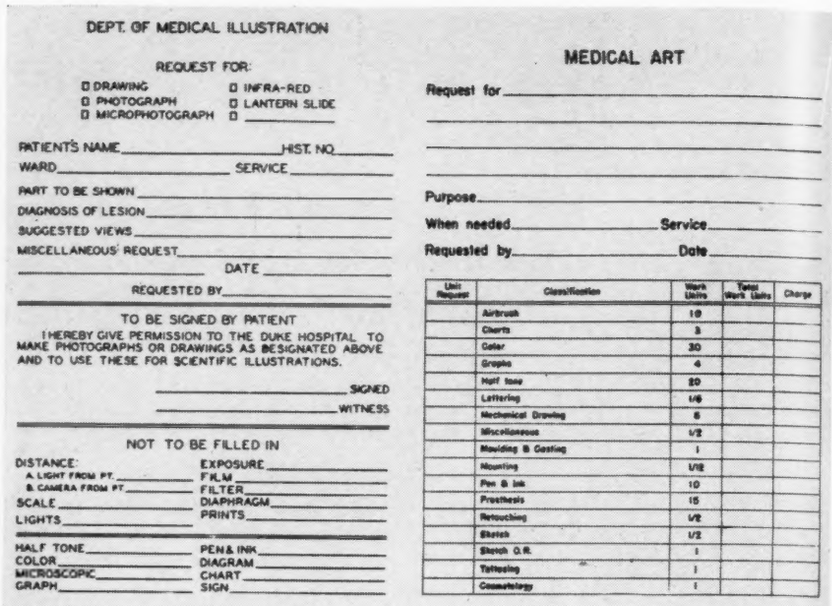
ART SECTION
1 Typewriter
1 Office desk and chair
? Files (at least four letter size and two 3 by 5 inch)
1 Desk light
1 Office telephone
1 Medical dictionary
1 Large (unabridged) dictionary
2 Drafting tables with drawers
1 Long work table
2 Fluorescent adjustable desk lights
2 Large storage cabinets
3 Adjustable swivel chairs
1 Drymounting machine and tacking iron and tissue (5 by 7 inches and 11 by 14 inches)
1 Complete set of lettering guides and pens
1 Airbrush
3 T-squares
4 Assorted triangles
6 French curves
1 Adjustable curve
1 Drafting set instruments
2 Cutters (paper and cardboard)
Fluorescent overhead lights
General stock of drawing and mounting papers, pencils, brushes, water colors, erasers

PHOTOGRAPHIC SECTION
1 Lens f:4.5—21 cm. anastigmat lens
1 5 by 7 inch view camera
2 Dozen 5 by 7 inch double film holders for view camera
1 Compact stand for camera
1 16 mm. motion picture camera with lenses
1 35 mm. camera with detachable 50 mm. lens equipped with copying attachment
2 Double light standards with reflectors for No. 2 photofloods
1 Strobotron
1 Mirror on adjustable stand to use with strobotron
1 Small hand reflector with battery case for No. 5 flash lamps
1 Adjustable chair for posing patients
1 Head rest to immobilize patient
1 (each) White and black backgrounds
2 Tripods with tilt tops (1 for 35 mm. camera and 1 for movie camera)
1 Photomicrographic outfit
1 Exposure meter
1 Desk and chair
? 16 mm. sound and silent projectors
? Lantern slide projectors (4 by 5 inch and 2 by 2 inch)

DARKROOM
1 5 by 7 inch automatic focus enlarger with reducing attachment
1 35 mm. precision enlarger
1 Professional printer
? Enameled trays (various sizes)
? Sinks
? Developing, fixing and washing tanks
? Small accessories (lights)
1 Print washer
1 Print dryer
General stock of chemicals, photographic papers, film.

As to the personnel of the new division—a note of caution. This is no place to economize. Rather let us say, this is no place for false economy. Hiring inadequately trained personnel in order to cut financial corners will result in a division that will never get off to a good start and will be unlikely to develop into a project worthy of the time and care that must necessarily go into its planning and operation.

All initial personnel should be expert and well trained. Thereafter, it will be relatively simple to take on



DEPT. OF MEDICAL ILLUSTRATION

REQUEST FOR:
☐ DRAWING ☐ INFRA-RED
☐ PHOTOGRAPH ☐ LANTERN SLIDE
☐ MICROPHOTOGRAPH ☐ _____

PATIENT'S NAME _____ HIST. NO. _____
WARD _____ SERVICE _____
PART TO BE SHOWN _____
DIAGNOSIS OF LESION _____
SUGGESTED VIEWS _____
MISCELLANEOUS REQUEST _____
_____ DATE _____
REQUESTED BY _____

TO BE SIGNED BY PATIENT
I HEREBY GIVE PERMISSION TO THE DUKE HOSPITAL TO MAKE PHOTOGRAPHS OR DRAWINGS AS DESIGNATED ABOVE AND TO USE THESE FOR SCIENTIFIC ILLUSTRATIONS.

_____ SIGNED
_____ WITNESS

NOT TO BE FILLED IN

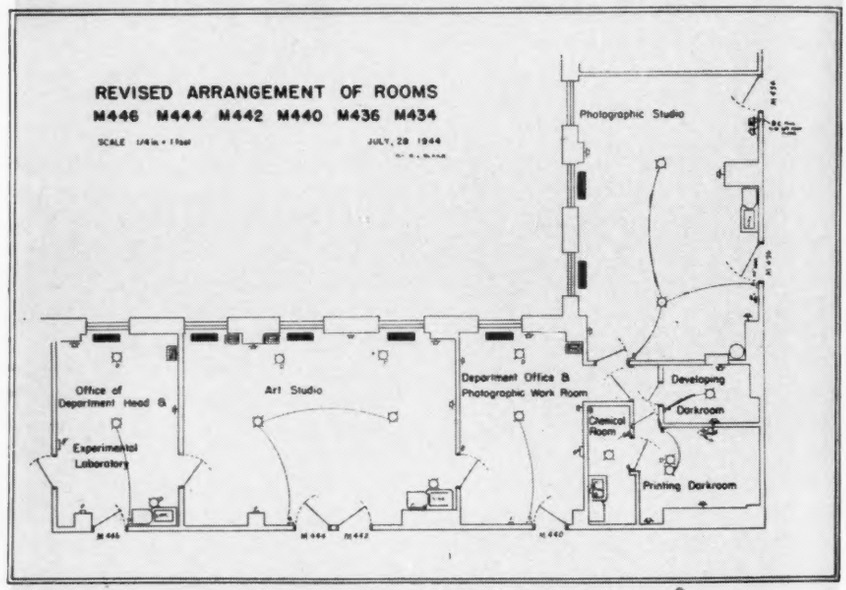
DISTANCE: A. LIGHT FROM PT. _____ B. CAMERA FROM PT. _____
SCALE _____
LIGHTS _____
EXPOSURE _____
FILM _____
FILTER _____
DIAPHRAGM _____
PRINTS _____
HALF TONE _____ PEN & INK _____
COLOR _____ DIAGRAM _____
MICROSCOPIC _____ CHART _____
GRAPH _____ SIGN _____

MEDICAL ART

Request for _____
Purpose _____
When needed _____ Service _____
Requested by _____ Date _____

Unit Request	Classification	Work Units	Total Work Units	Charge
	Airbrush	10		
	Charts	3		
	Color	30		
	Graphs	4		
	Half tone	20		
	Lettering	1/6		
	Mechanical Drawing	6		
	Miscellaneous	1/2		
	Mounting & Casting	1		
	Mounting	1/12		
	Pen & Ink	10		
	Prosthesis	15		
	Retouching	1/2		
	Sketch	1/2		
	Sketch O.R.	1		
	Tattooing	1		
	Cosmetology	1		

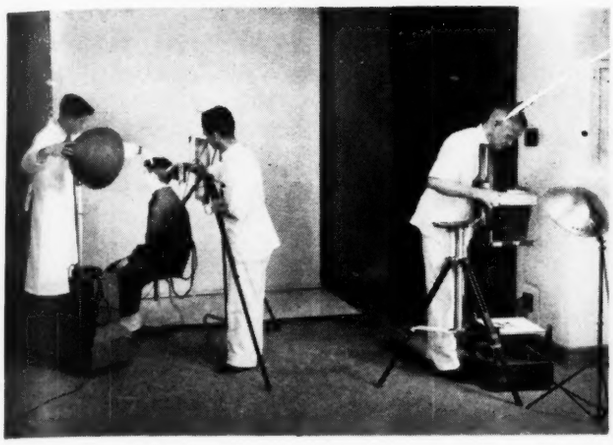
Left: Requisition for photographic service includes patient's release. Right: Art requisition is broken down into work hours spent in each operation.



Above: The complete floor plan of the medical illustration division.

Budget for Medical Illustration Division

Head of the division (Medical artist with professor's rank)	$ 5,000—10,000
Medical photographer (Staff rank)	$ 2,500— 5,000
Assistant	$ 1,200— 2,000
Cost of photographic equipment (approx.)	$ 6,000— 6,000
Cost of art equipment (approx.)	$ 1,000— 1,000
Total of first year	$15,700—24,000
Running expenses thereafter: (excluding salaries)	
Photography per year (for supplies)	$ 1,500
Art (for supplies)	$ 500
	$ 2,000
Running expenses thereafter: (including salaries)	
Photography (salaries)	$ 2,500— 5,000
(supplies)	$ 1,500— 1,500
Art (salaries)	$ 5,000—10,000
(supplies)	$ 500— 500
Assistant (salary)	$ 1,200— 2,000
	$10,700—19,000



Above, left: A portion of the large photographic studio which is separated from the art studio (above, right) by the department office. The photographers rely entirely on artificial lighting; on the other hand, the art studio is oriented to obtain all possible daylight.

Above, left: Specialist at work in the printing room. Above, right: Special equipment used for photographing the fundus of the eye. Below, left: In the central office the secretary records requests and maintains departmental records. Below, right: Division chief's office.

additional persons on an apprentice basis and teach them the hospital's particular system and the staff's particular method and style. A thoroughly experienced person with an excellent background should be employed to head the division. This man, or woman, should be experienced in *all* phases of medical visual education.

He is usually a trained medical artist, as he has received the necessary basic training through organized schools.

One experienced medical photographer, not a specialist in any one branch of photography, but one familiar with general photographic problems and capable of handling photographic requests for movies, photomicrographs, photographs of eyegrounds, specimen photography, clinical photography, copies of x-rays and charts, should be employed. A good technician will be needed as assistant to the artist and photographer. This person can be trained to take over special work, such as lettering, chart work and darkroom technic, when the need arises. This minimum will serve until the opera-

tion becomes expanded and other assistants and a secretary are needed.

An initial budget to include salaries, equipment and running expenses and based on our own experience is listed in the table that appears on page 78.

Here, something of our own operation and history might be of interest in determining the path to take in setting up a division of this type. One medical artist and a part time photographer were responsible for answering illustration requests during the first four years. Soon thereafter plans were formulated to establish a division of medical illustration. The work up to this time had been limited to medical drawings and clinical photography.

Scope of Activities Increased

At later dates after the division was established, personnel was increased and other services were added. Two trained medical artists, one artist, one letter artist and cosmetician, three medical photographers, a darkroom specialist and a full time secretary now staff the division. The scope of activities has increased to include the preparation of all phases of medical illustration and medical visual education aids for all the schools relating to medicine offered by the Duke University School of Medicine and Hospital.

The trained medical artist specializes in the preparation of all drawings of a medical nature which obviously covers an extremely wide range of subject matter and technic. Through his training and experience he is able to produce an illustration that will accent the point stressed with clarity and realism. It is his problem to bring this point to its simplest form, both in drawing and in method of reproduction.

This is the advantage the artist has over the photographer, who is compelled to photograph what the camera sees regardless of any extraneous objects concerning the illustration which might be in the field. However, the medical photographer has the advantage over the artist in being able to make very accurate reproductions in a much shorter length of time and with a great deal less expense, excluding, of course, the cost of equipment.

The medical artist also works in plastics. He cooperates with the plastic surgeon in designing and manufacturing anatomical restorations, such as fingers, hands, ears, noses and so on. Working with the plastic surgeon, he models improvements and submits plaster casts of the desired effect to serve as a blueprint for the surgeon in charting the operation.

Another phase of our work is epidermal injection. This is valuable in the eradication of scars and blemishes and in the supplementing of natural pigmentation of grafted skin areas. We have recently been able to show satisfactory results with this method in hiding corneal scars.* These aids may seem removed from what is ordinarily understood to be the scope of the medical art division, but mastery of these technics has earned for us the esteem of the staff and has in some measure served to justify our existence on a separate budget.

The letter artist is responsible for the production of the many charts and graphs used in the hospital and medical school. These charts must be accurate in all cases and are valuable in scientific research and teaching. The lettering of the many exhibits which the departments of the medical school enter is also handled by the letter artist. In addition, our letter artist has become expert in cosmetic technics. She has been trained at a New York salon in the application of a substance which conceals scars or other disfigurements.

The photographic work of our division is equal in importance with our art work. Our skilled photographers develop and make possible complete clinical records of exceptional cases. They produce lantern slides and take movies of clinical procedures, including operations which may also be recorded in drawings by the medical artist. A specialty of our section is color photographs of the fundus of the eye. Our photographic service makes possible the accurate portrayal of any visible clinical findings and makes available to our large house staff any and all forms of visual aid.

Convinced of the multiple services which a division of visual aid can render and aware of the advantage of incorporating such a service in your own organization, you may well ask, "Where am I to find this personnel which you deem so necessary to successful operation?"

In recognition of the fact that experience in actual medical art is necessary to participation in this field, several recognized schools of medical art have been preparing students for this work for many years. Contact with the Association of Medical Illustrators will serve as a lead in obtaining the right persons for your division. Recently, courses in medical photography have been offered at a few places, and if you are seeking the services of a qualified medical photographer, communication with the Biological Photographic Association will put you in touch with someone who can staff this section of your division.

More Will Be Trained

As yet, there is only a limited number of people trained in medical visual education. If enough administrators evince an interest, there will be many more trained. It is up to you. The schools will meet any demand that is made. Tentative plans under way with the Association of Medical Illustrators and the Biological Photographic Association call for the betterment of existing facilities and the creation of new methods. These associations will be glad to aid you in any way toward the establishment of your division.

With regard to the scope and extent of activity that may be anticipated in a medical illustration division, our yearly report for 1946 may be of interest. We prepared work for 28 departments, the heaviest demand coming from neurosurgery, endocrinology, anatomy, plastic surgery, pediatrics, surgery, pathology, psychiatry and medicine. Ours is a teaching hospital and the experiences of other hospitals may show a different distribution.

Concrete services which we rendered are shown in the sample medical art and photography reports which are reproduced in this article. For instance, we prepared 2136 pictures for publication and teaching last year and answered 2540 requests for lettering. We made 544 charts and graphs, 3830 copy negatives, 4015 lantern slides, 3545 colored films of patients, 4611 black and white films of patients and 21,149 prints. Finally, 8941 feet of colored motion picture film were produced.

*Pickrell, K. L., and Clark, E. H.: Tattooing of Corneal Scars With Insoluble Pigments, Plastic and Reconstructive Surgery 2:44-59 (January) 1947.

We prepare a monthly report, as well as an annual one, and are thus able to anticipate monthly fluctuations in work load. For instance, we are able this way to anticipate a heavier schedule in the spring when medical meetings require the preparation of numerous papers and exhibits. For these medical meetings we have prepared 17 exhibits, many of which have received national recognition. From January 1946 to January 1947, in addition to our routine work, we prepared five full exhibits and did a great deal of work in drawing and redrawing plans for new buildings, another worthy and as yet unmentioned service.

We chart our services both by unit and by time consumed on a job; thus, we are able to account for the work load and hours devoted to every request we handle. For instance, it may take us a half hour to do a sketch and it may take us thirty hours to do a full color drawing. Yet each of these appears as one unit on a job order.

By carefully organizing a medical illustration division and by obtaining efficient administrative talent; by allotting your division a separate budget so that it is beholden to no other department and is available to all staff members and divisions; by a careful and a business-like approach and with the aid of medical art and photographic schools and related associations, you will find that you will be able to set up a medical illustration division that will more than compensate for the time and care which you will put into its institution. This has been our experience at Duke University.

Democracy Goes to Work in Gary

as Methodist and Mercy Hospitals Admit Negroes to the Medical Staff

AN INDUSTRIAL community of 130,000 people at the foot of Lake Michigan, Gary, Ind., has always had a certain amount of racial tension. Nearly a third of the population is Negro. Last winter the race problem flared momentarily when white pupils in one of Gary's public high schools went on a protest strike against sharing classroom facilities with Negroes. According to Don F. Datisman, managing editor of the Gary *Post-Tribune,* the protest movement in itself was not particularly widespread or virulent at first. However, a few misguideed children and their parents soon became tools of adult groups which make a business of racial intolerance, with the result that the strike was prolonged and the populace, unnecessarily embittered.

Admit Negro Physicians

With only a single hospital of fewer than 25 beds devoted exclusively to care of Negroes, Gary's two large hospitals have long accepted and cared for Negro patients on an equal basis with white patients. Last month, the Methodist and Mercy hospitals took a great step toward achieving racial tolerance in Gary when their boards voted to permit practice by qualified Negro physicians. On October 1 this year Negro doctors will be allowed to apply for staff membership in both hospitals.

Supervised at First

"Of course," a spokesman for one of the hospitals said, "Negro physicians must qualify exactly as present staff members must by proper training and experience. They must serve for a time under supervision before full privileges will be extended to them."

Action by the hospitals' boards followed similar action by the medical staffs a few weeks earlier, it was explained.

"The admission of qualified Negro doctors to Gary's hospitals means that another step has been taken to make the practices of democracy equal its shibboleths," said an editorial in the *Post-Tribune*. "This is progress in democracy and community life.

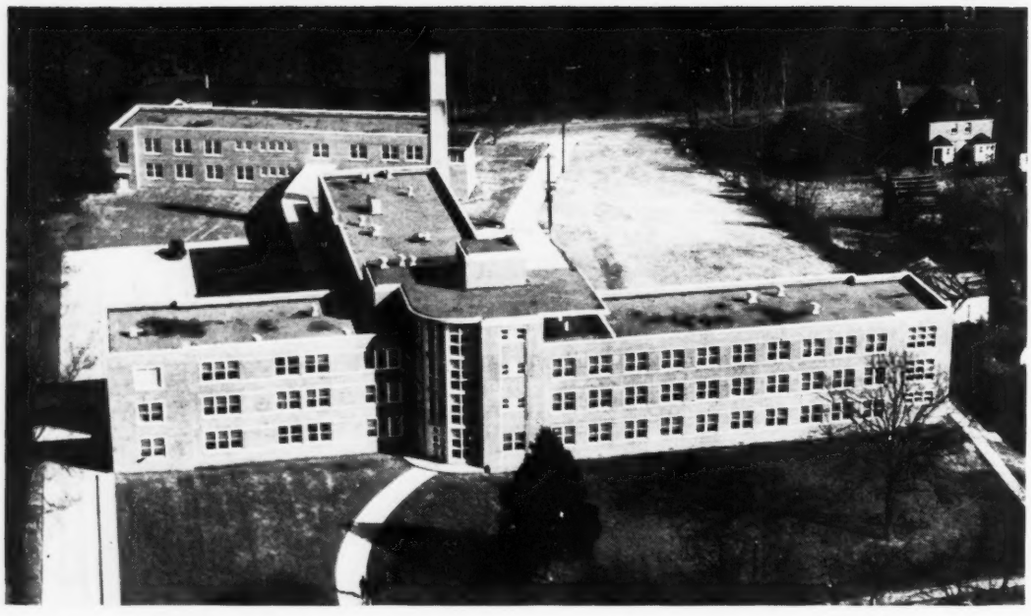
"The change in the actual operation of the hospitals as a result of this action will be almost imperceptible but the psychological difference will be very great. There are probably only a few Negro doctors who will be able immediately to measure up to the requirements, but the fact that there is no color discrimination will block further criticism.

"The presence of qualified Negro doctors and their patients in the hospitals will mean little change because many of the patients are there now. Negro patients have been accepted by both hospitals for years but Negro doctors have had to hire white doctors to take care of them.

Tend to End Restrictions

"The admission of qualified Negro doctors is not new in hospital practice in this country. Hospitals in many communities have had Negroes on their staffs for many years and the tendency is to end those restrictions where they have continued. Therefore, the local action is simply in line with what is being done elsewhere as other communities have awakened to new problems.

"This problem has been under discussion for the last three years and the boards are to be congratulated for having ended the talk and taken this action. Talk is necessary until everyone has had a chance to unburden his mind or emotions, but it cannot go on forever."



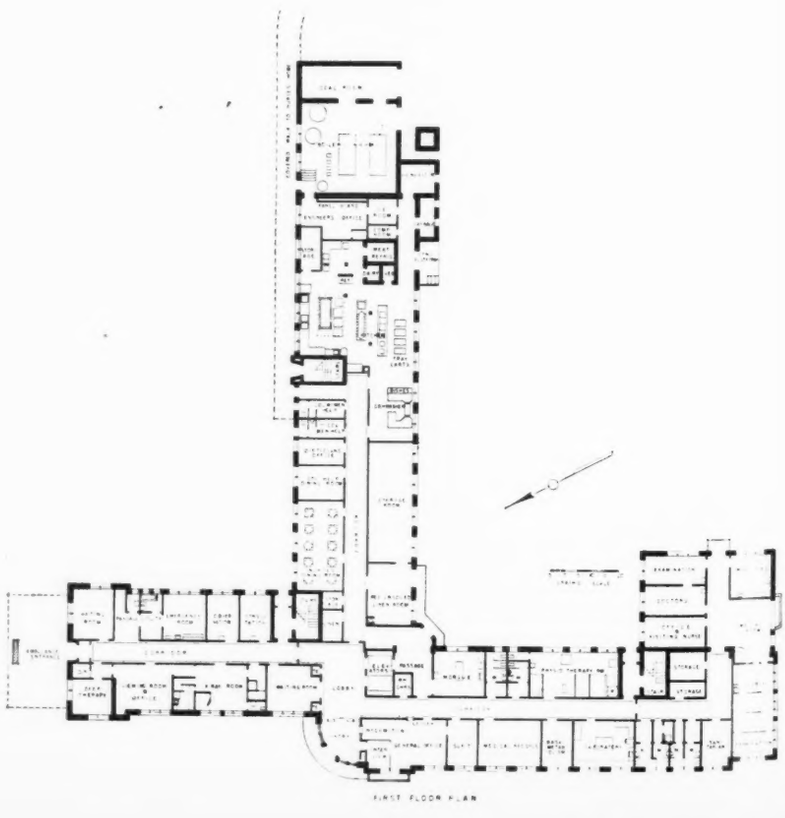
AERIAL VIEW OF MARTINSVILLE GENERAL HOSPITAL AND NURSES' HOME

Martinsville General Hospital Serves Six Counties in Two States

ALFRED M. LUBLIN
Lublin, McGaughy and Associates
Architects and Consulting Engineers
Norfolk, Va.

THIS project was sponsored by the Martinsville General Hospital, Inc., Martinsville, Va., a nonprofit organization, and was financed through a Federal Works Administration grant of $366,000, a loan of $236,000 and public contributions. The institution was created through the efforts of H. A. Ford of the Kiwanis Club and E. P. Waller, acting as chairman of the building committee. Dr. John Shackelford, formerly owner and operator of the Shackelford Memorial Hospital of Martinsville is chief of the medical staff.

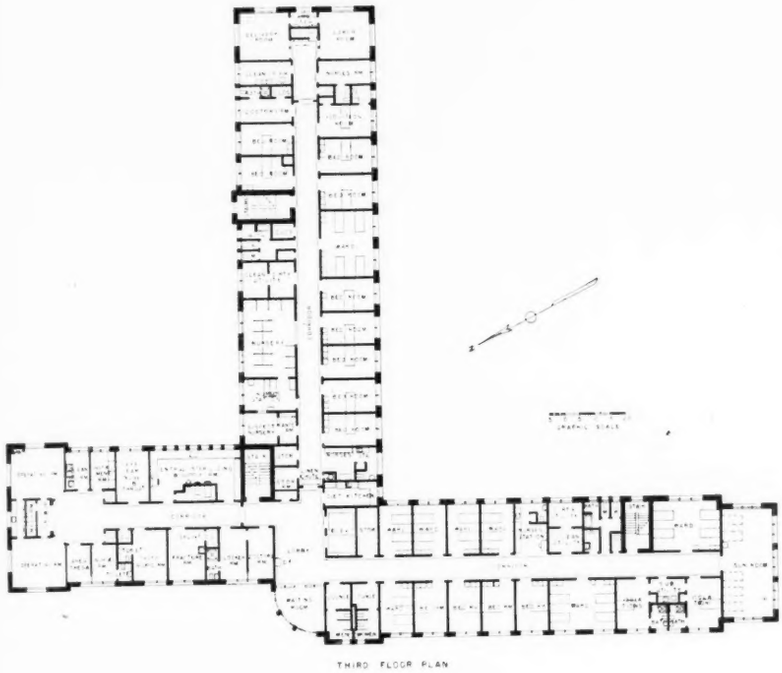
The hospital serves the city of Martinsville, Henry and Patrick counties and a part of Franklin and Pittsylvania counties in Virginia, also a portion of Rockingham and Stokes counties in North Carolina; the total estimated population is 118,181. It has a capacity of 80 beds and 17 bassinets and can accommodate 120 patients in an emergency. The nurses' home is designed for a staff of 40 and contains three classrooms.



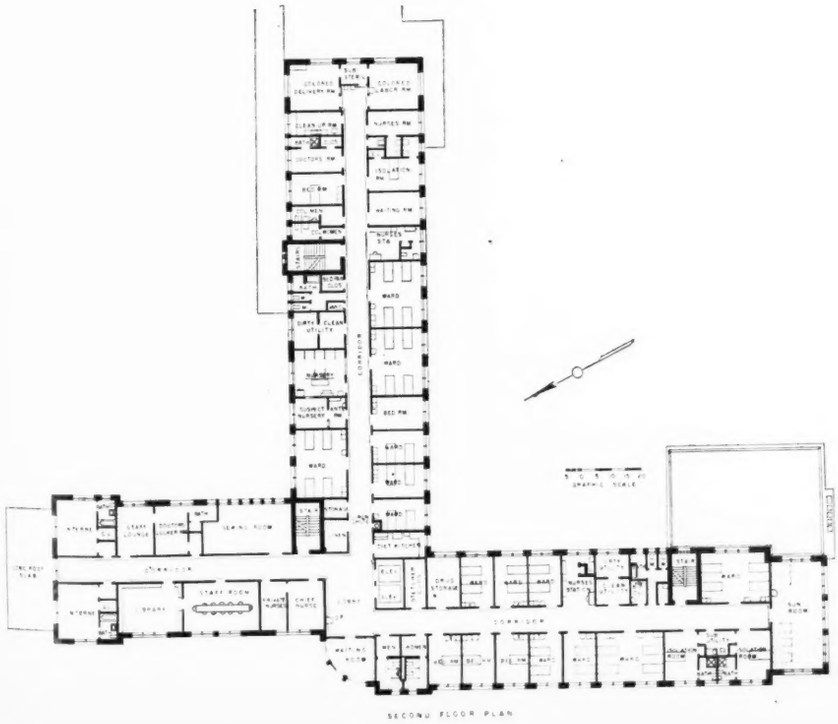
FIRST FLOOR PLAN

The first floor of the hospital (shown on the opposite page) is devoted to administrative, nursing, dietetics and engineering offices; examining rooms; physical therapy department; x-ray department; kitchen; staff and employes' dining rooms; storage rooms; morgue and facilities for a public health clinic. On the second floor (bottom of page) are labor and delivery rooms for Negro patients, with a regular nursery and a suspect nursery for the infants. This floor also houses the staff lounge, locker room and conference room and interns' quarters. The third floor includes delivery room, labor room and nurseries for white patients, as well as operating rooms.

PLANS OF THE NURSES' HOME APPEAR ON P. 84.



THIRD FLOOR PLAN



SECOND FLOOR PLAN

OUTLINE OF CONSTRUCTION DETAILS

CONSTRUCTION: Hospital and nurses' home, face brick and cinder block with Indiana limestone trim and canopies of reinforced concrete. Floor construction, bar joists and concrete; interior partitions, terra cotta tile. Stairways, reinforced concrete with pipe railings.

HEATING: High pressure boiler plant furnishes steam for sterilizers and kitchen equipment; converters used for domestic hot water and forced hot water heating system; convectors, of cabinet type.

LIGHTING: Incandescent lighting except in kitchen which is equipped with fluorescent lights.

WALLS: Ceramic glazed tile in operating, sterilizing and private bathrooms; salt glazed tile in public toilets and kitchen.

FLOORING: Asphalt tile and base; grounded terrazzo floors in operating rooms.

CEILINGS: Acoustical plaster in corridors and obstetrical department; white plaster on all other ceilings.

CALL SYSTEM: Lamp annunciator.

ELEVATOR: Automatic, self leveling, 100 feet per minute.

KITCHEN: Electric range; steam cooker.

X-RAY EQUIPMENT: Complete diagnostic and therapeutic equipment.

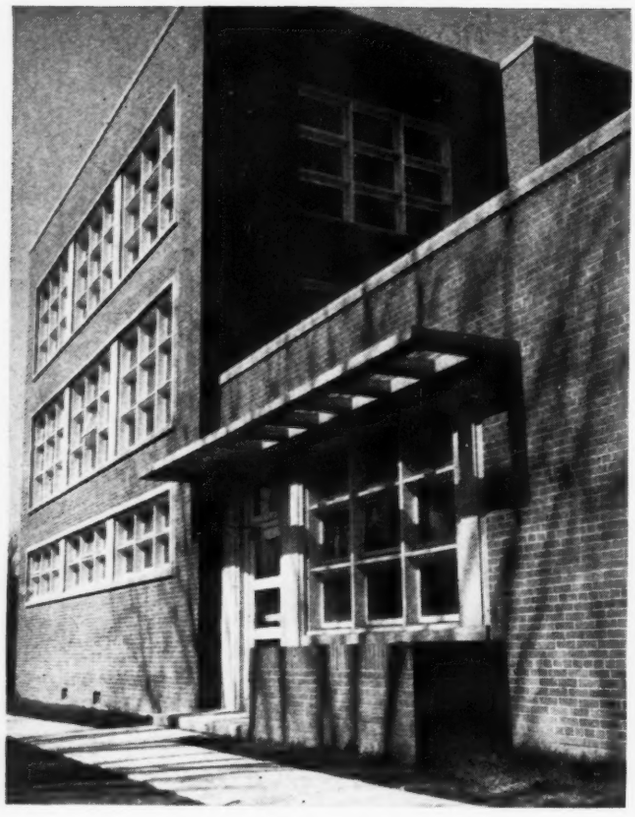
SPECIAL FEATURES: Facilities for a public health clinic.

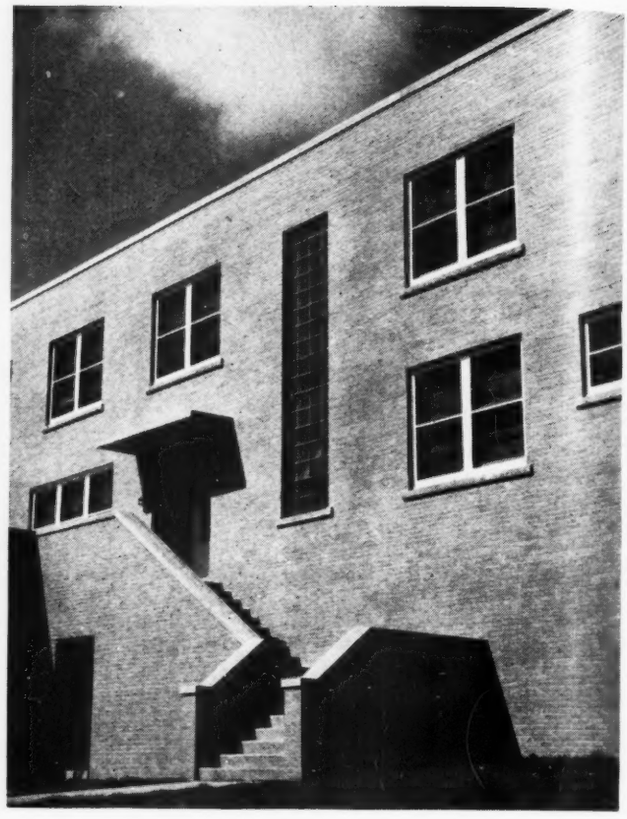
COSTS: Hospital contains 784,531 cubic feet; nurses' home, 174,028; total, 958,559 cubic feet. Total cost of buildings, exclusive of land, was $738,283, divided as follows:

General contract	73.0%
Elevator	1.5
Surgical equipment (except x-ray)	4.0
X-ray	3.0
Kitchen equipment	2.0
Refrigeration and cold storage	1.0
Furniture and furnishings	11.0
Architect's fee	4.5
	100.0%

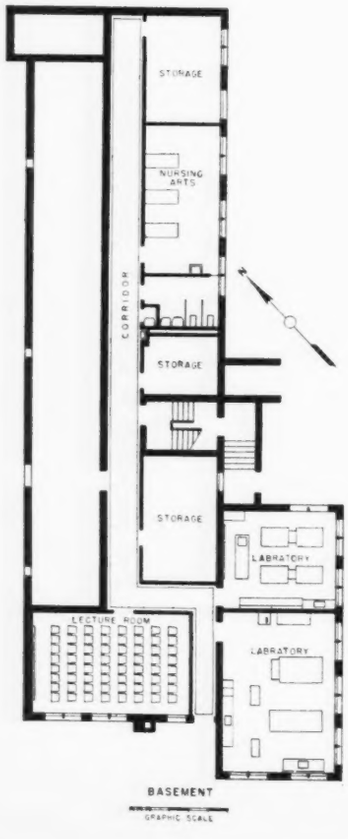
The general contract which amounted to 73 per cent of the total cost is broken up as follows:

Plumbing	8.3%
Heating	10.0
Electrical	4.4
General	77.3
	100.0%



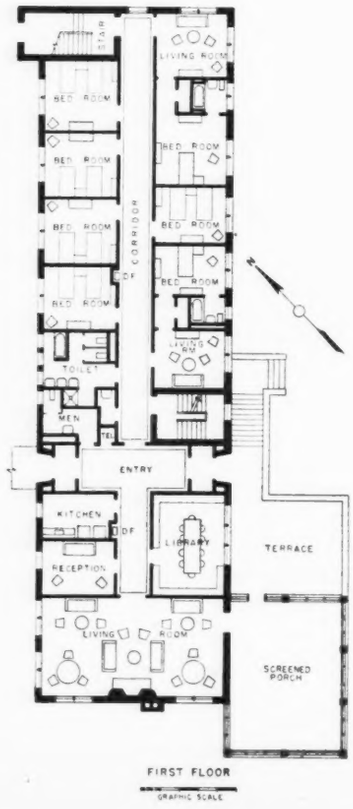


Above, left: Entrance to the nurses' home; right: health clinic entrance. Below: The two story nurses' home is connected with the hospital by a covered walk. In the basement are the nursing arts classroom, lecture room and laboratories. The first floor includes living room, kitchen, reception room and library, in addition to five double and two single bedrooms. Each of the single rooms has a private sitting room in connection with it. The remaining bedrooms and a lounging room are located on the second floor.



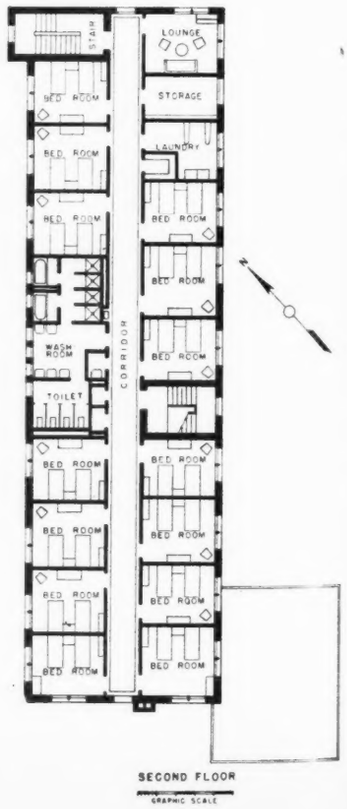
BASEMENT

GRAPHIC SCALE



FIRST FLOOR

GRAPHIC SCALE



SECOND FLOOR

GRAPHIC SCALE

Goodbye, Utility Room

ANN KIRCHNER, R.N.
Director of Nursing, Lying-In Hospital, Chicago

THE process by which the utility room—a most essential area in the hospital—has become obsolete has been a gradual one precipitated by three main factors in the design for living in the modern hospital: the trend toward individualization of the patient is the most important one; the development of the central supply room is the second, and early ambulation gave it the coup de grâce.

The functions of the utility room were:

1. To store materials used in patient care, principally those concerned with the hygienic care of the patient.
2. To dispose of waste materials.
3. To cleanse and sterilize equipment used in common by patients.
4. To prepare some of the materials used in treatment of the patient, especially rectal treatments and unsterile procedures.
5. In the more remote past to handle sterile equipment.
6. In some instances to take care of flowers.
7. In at least one elaborate setup medicines were dispensed from the all-purpose utility room.

Where are these functions to be performed now?

Taken Over by Central Supply

The storage function and the preparation and sterilization of equipment have been taken over by the central supply room with added economy and the obvious advantage of taking away duties from the clinical field which tended to detract from the time to be spent on nursing care. Less equipment is needed when several units share the use of the same materials.

The care of equipment under the direct supervision of a person who devotes her entire time to this type of work is advantageous. Subsidiary personnel can be taught to care for all types of equipment and effectively handle every variety of sterilizer. There is a uniformity of equipment impossible to attain any other way. The number of sterilizing units needed throughout the hospital can be markedly decreased.

The bathroom adjacent to the patient's room or ward was first used in the more luxurious parts of the hospital. It soon became apparent that there was a practical value in this arrangement. It is safer to dispose of waste in the patient's own unit than to bring contamination to a common room. It is more esthetic to limit the unpleasant odors implicit in care of any bed patients to a small area.

It is more efficient to have the equipment used in patient care close at hand rather than to walk long corridors to obtain it.

The care of equipment used for one patient only is much simpler. It is not necessary to resort to constant sterilization of utensils that are not kept sterile.

Finally, the patient's needs are supplied quicker from an adjacent room than from a central area.

The final death blow to the utility room was struck when early ambulation became the widely accepted mode of therapy. The patient became self sufficient more rapidly, especially when he had access to toilet and shower facilities close at hand. One of the most embarrassing and unpleasant aspects of being a patient is the return to childish dependence on someone to supply facilities for ordinary hygienic functions. With early ambulation and a comfortably close bathroom these aspects can be eliminated for many types of patients early in the hospital stay. It is obvious that the reduction in nursing time per patient is directly proportionate to close availability of bathroom facilities.

The hospital bathroom must of necessity be more elaborate than is the hotel or home bathroom. It must adjoin one or more rooms or wards. It should have one or more enclosed toilets to ensure the privacy most people consider essential. It should have a shower stall with comfortable sitdown shower arrangements. A dressing table and wash bowl complete the facilities for the patient's self care.

The equipment which the nurse will use for treatments and bedside care should occupy the other half of the room. Individual stainless steel compartments with two or more shelves for the patient's equipment, including the bedpan, are needed. The top of these compartments affords working table space. A hopper with a toilet type of flusher and a wash bowl for hand care complete the setup.

This may seem to be an expensive and elaborate arrangement but in the end it will pay dividends since the most expensive single item in patient care is probably the salary of the persons rendering service.

General Workroom Needed

It should be stated here that there is still need for a type of room which is generally called the workroom and might be considered the realm of the subsidiary worker as most of the duties performed there are delegated to such a person. It might even be considered to be her headquarters when not engaged in specific duties related to the patient. Flowers can be arranged there; certain supplies can be prepared, and the equipment which is on its way to the supply room can be stored in the contaminated area after some simple preparatory procedures, such as rinsing, disposing of used linen and other materials, have been done. Here an electric stove or a gas plate may be needed to heat compresses or prepare plasters or poultices. There is a limited use of these today but some provision should be made for the occasional as well as the routine.

Presented at the Tri-State Hospital Assembly, May 1947.

They Convalesce in Comfort

and make room for the acutely ill

A NURSES' home successfully converted into a convalescent hospital to which patients are transferred as early as possible, thus freeing badly needed beds on the general surgical and medical floors—that is the solution to the bed shortage worked out recently by John R. Smiley, administrator of St. Luke's Hospital, Kansas City, Mo.

In addition, Mr. Smiley points out, the concentration of convalescent patients, all ambulatory, in a special building designed for their care permits economies in nursing, food and other services which substantially reduce the cost of caring for these patients.

"The new convalescent building has been open about four months now," Mr. Smiley said, "and while our operating cost figures are possibly not conclusive at present, it is plain that we are going to save these patients, and the hospital, a lot of money."

Mr. Smiley also considers extremely important the psychological benefit to patients of pleasant physical surroundings and associations in dining room, lounge and sunrooms with other patients who are convalescent.

Accommodations for 95 persons are provided in the 53 private rooms, 17 double rooms and two 4 bed wards at the new building, which is known as "St. Luke's Convalescent Annex." The unit is north and slightly west of the main hospital. Its entrance leads to a reception room and lounge furnished like a hotel lobby. It is planned that patients will receive guests in the lounge. A library is near the lounge.

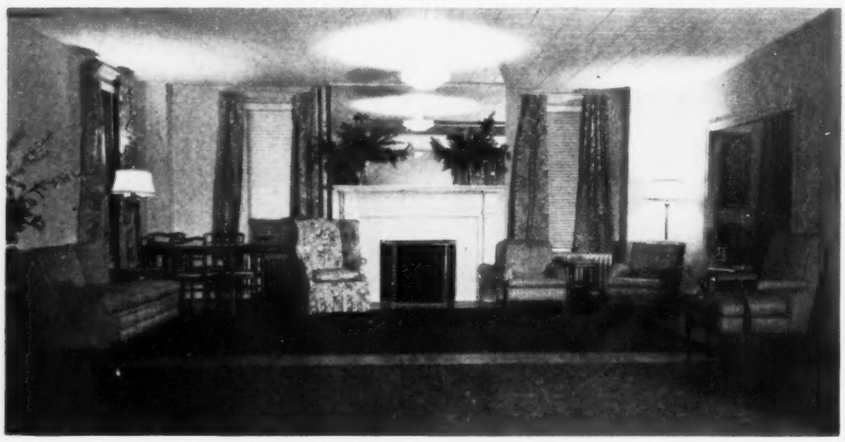
There are five floors of rooms in the new pavilion, and even the tan tiled floors belie a hospital atmosphere. The private rooms are furnished with light, maple colored metal furniture. Each contains a bed, dresser, table, easy chair and closet. A bathroom with shower is shared with a double room.

The double rooms are furnished in the same manner but have no dresser. The two 4 bed wards, one on the fourth floor and one on the fifth floor, also have baths, closets and easy chairs.

On each floor is a large solarium furnished with couches and easy chairs. The solariums are used as lounge rooms for the patients.

Patients go to the basement dining room for meals. Designed to seat 45 persons, the dining room is furnished with tables that seat four persons. Four waitresses serve the meals to consecutive small groups.

Also in the basement is the stainless steel, modern kitchen in which meals for 150 persons can be prepared. Staffed by a dietitian and two cooks, the kitchen provides meals for the pavilion and for the St. Luke's Children's Hospital, just north of the new unit. Meals are sent on an electric truck to the children's hospital.



The general lounge looks like a hotel lobby.

Admitting office of the convalescent unit.

The kitchen has its own baking facilities, deep-freeze locker and garbage disposal room.

The basement also has an exercise room for patients who are able to take mild exercise. It eventually will be equipped with gymnasium facilities, Mr. Smiley said.

Patients are transferred from the hospital to the convalescent unit any time from 7:00 a.m. to 7:00 p.m. each day by station wagon, and an attempt is made to transfer as many as possible at one time. The procedure is the same as a transfer from one room to another within the hospital and the patient's entire chart goes with him to the convalescent unit. A laboratory technician makes scheduled trips to this annex to make any necessary laboratory tests and the building is equipped with an electrocardiograph machine so that readings can be taken and the physician can see the results before he leaves the building. All x-ray examinations, however, must be performed at the hospital.

Only ambulatory patients from St. Luke's who no longer require intensive treatment are admitted to the new unit. The unit contains two white tiled treatment rooms for minor medication only.

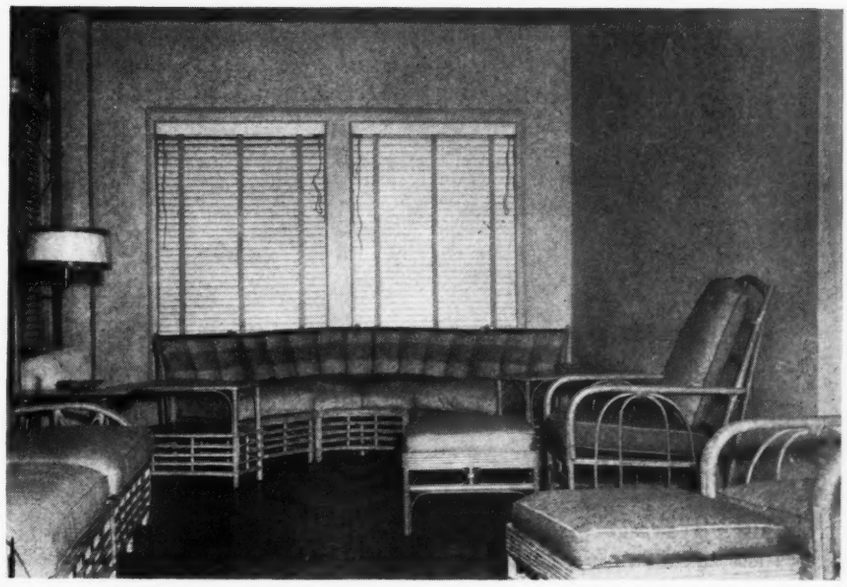
Florence Parsons, who has been assistant superintendent of nurses in the main hospital, is in charge of the pavilion. A graduate nurse is on duty on each of the five floors, with additional care furnished by nurse's aides. All administrative records are kept in the main hospital.

Patients and their families are enthusiastic about the unit, Mr. Smiley reported, and most staff physicians believe it provides them with an opportunity to do more, in a shorter space of time, for their patients who are convalescing following surgery or acute illness.

It has been found that many requests for transfer to the convalescent building are the result of descriptions of the unit given by patients who have been transferred to it and who return to the hospital to visit their former ward or room mates. Occasionally, a patient transferred to the convalescent unit becomes bedfast, necessitating a return to the hospital. However, as soon as he is on his feet again, he usually asks to be sent back to the convalescent unit. All of which indicates what the patients think of St. Luke's new venture.

Patients select books from their own library.

The dining room is furnished with tables for four.



Solariums on each floor are used as lounge rooms.

Fairness to All Is the Best Basis for Settling the Compensation Question

SISTER HORTENSE McCABE
St. Joseph's Hospital, Philadelphia

COGNIZANT of the fact that it is rare to find even a few hospitals in the same area employing a similar method of payment to pathologists and radiologists, I recently undertook a short survey of existing conditions in a selected group of hospitals, the results of which will be subsequently given.

The hospital administrator's interest in departmental problems is paramount. It is highly important that the department heads participate in the formulation of relating policies and that their responsibilities be specified, properly understood and delegated.

Should Help Form Policy

Medical specialists should participate in the formulation of hospital policies in reference to their respective services. When and where this practice is effective, the department heads' interest in the hospital is increased. Interest leads to greater cooperation and the whole process results in greater efficiency in the department, loyalty to the institution and better service for the patient.

Some other reasons for the participation of department heads in policy making are:

1. The participants are qualified professional experts and merit such privilege. They have the advantage of frequent association with contemporaries in their field and the pooling of their ideas naturally results in better organization of departments.

2. The formulation of policies requires the highest professional, administrative, legal and accounting ability available.

3. Policies should be subject to periodical reviews and revisions. Any changes should be agreed upon and confirmed by all formulators.

4. The subject of compensation should likewise be a cooperative procedure; a straight salary places the expert on an employe basis which is not in accord with his professional dignity. There should be a contract arrangement on a business basis, agreeable to both the medical specialist and hospital authority.

Hospital administrators should be keenly interested in and sympathetic with all problems concerning the two departments under discussion. They should share their responsibilities with the department heads. Regular conferences and consultations will be beneficial to all concerned. These will result in better service to the patient and greater satisfaction to the medical expert and the hospital authorities. The professional technical expert should be encouraged to render personal service to the patient. Staff members should feel free to enter the medical expert's office for advice, interpretation of reports and diagnostic aids. Dealing exclusively with technicians and written reports is not conducive to interest and confidence. Many situations require conferences with the "chief."

Responsibilities of department heads should be well defined and delegated to establish the coordination necessary to the efficient hospitalization of patients. Some of the major responsibilities of the radiologist and of the pathologist might be:

1. Determining the number of hours devoted to (a) supervision and direction of the general laboratory; (b) tissue and necropsy pathology; (c) teaching, research and consultations.

2. Participating in policy formation.

3. Attending and participating in staff meetings.

4. Regulating and delegating duties of technicians.

5. Attending conventions.

6. Determining the number of other workers needed.

7. Conferring with other department heads to ensure cooperation for all.

8. Conferring with the administrator on problems of inadequacy of equipment and supplies.

9. Arranging for the service to be covered for twenty-four hours.

10. Supervising monthly and annual reports.

In order to ascertain the existing methods of compensating radiologists and pathologists, a questionnaire was sent to 30 hospitals. From the hospitals that answered, the following data were obtained:

Concerning radiologists: six were on a salary basis; six, on a salary plus a commission; four, on contract, and three, on commission.

Concerning pathologists: 19 were on the salary basis; four, on a salary plus commission, and three, on a contract basis.

Salary Heads the List

From this small sampling it can be readily seen that the salary basis heads the list for methods of compensation. However, the results of such a limited study could not be conclusive. Methods of compensation are extremely varied. Because of the diversity of methods, administrators and hospital trustees are naturally uncertain as to which is best and which operates fairly to all concerned.

In solving the problems of compensation it is well to remember that monetary return is not the only or cardinal factor. Many others, such as surroundings, atmosphere, satisfaction derived from service well rendered, opportunities for expansion and progress, are just as important (even more so to some experts) as is cash value.

In conclusion, there is no standard or ideal method of payment. Each hospital seems to be individual on this point. Whatever the plans are for compensating the radiologist and pathologist, they should be commensurate with their professional preparation, experience and status. They should result in high quality of service for the sick, satisfaction for the specialist and a self sustaining department for the hospital.

SMALL HOSPITAL FORUM

Increases Noted In Rates and Costs

IN THE group of small hospitals (100 beds and less) reporting to the Small Hospital Forum this month on rates and costs, increases were fairly consistent throughout the schedules submitted. Moreover, in this group of hospitals, the increase in rates charged for various services was about equal to the reported increase in costs over the period 1941-47.

The accompanying table shows in detail the average rates charged by these hospitals for rooms, operating and delivery rooms, anesthetics, penicillin and special nurses' duty today, a year ago and 6 years ago. Also shown are the total per patient day operating costs and daily payments made by governmental agencies and Blue Cross.

The figures in the table are averages. Individual hospitals reporting showed wide variations in charges and costs, according to type of hospital and community and geographical area. For example, the rates charged for single hospital rooms today vary from $13 in one hospital to $4 in another. Reported costs range from $13.93 per patient day in one hospital in an eastern city to $4.45 in a community hospital in the South. It is significant that, whereas such variations as this occur throughout the schedules of rates and costs reported, the rates of increase in the last year and the last six years remain about the same for all hospitals.

One peculiarity in the figures demands an explanation. The averages would indicate that anesthesia charges for minor operations have decreased in the last year. This is not the case. In many of the hospitals reporting, the charge has not been changed in the last year; in others, it has increased slightly. However, a number of hospitals were unable to report what the charge was a year ago. It happened that those which did submit complete reports included all the hospitals in which charges were comparatively high throughout. Thus the current figure, which is the average for all hospitals, is lower than the one for a year ago.

The tendency for hospitals to catch up with increases in costs by adding to the room rate rather than to special service rates is apparent in the figures. The rates charged for single, double and four bed rooms have increased commensurately with overall costs. The charges for operating room, delivery room and anesthesia services, on the other hand, have been increased somewhat more slowly. Delivery room charges, especially, have increased only 2 per cent on the average in the last year, and only 20 per cent since 1941; this is substantially less than overall costs, and probably less than actual costs of delivery room service itself.

On the whole, there is no indication here that these hospitals are basing charges in any way on "what the traffic will bear"—with the possible exception of one institution which was charging $10 for 100,000 units of penicillin a year ago, when the average charge was $3 and the next highest was $3.50. On the contrary, it seems safe to conclude from the figures that the hospitals have added to room rates only the reasonable increases made necessary by mounting costs and have been reluctant to hike charges for special services.

The reported figures show a woeful gap between costs and amounts paid by city, county and state agencies, compensation boards and Blue Cross plans, on the average.

Comparative Schedule of Rates and Costs in Hospitals of 100 Beds and Under for 1947, 1946 and 1941

Charges	Rate Today	Rate Year Ago	% Incr. Past Year	Rate in 1941	% Incr. Since 1941
Single room	$ 7.37	$ 6.43	15%	$ 5.07	45%
2 bed room	6.02	5.21	15	3.95	52
4 bed room	4.25	3.63	17	2.91	46
Operating room					
Major operation	15.00	13.25	13	11.13	35
Minor operation	7.75	7.22	7	6.66	16
Anesthetic					
Major operation	9.86	8.75	13	8.25	19
Minor operation	5.86	6.23	−6	4.75	23
Delivery room	9.93	9.75	2	8.25	20
Penicillin (100,000 units)	1.43	3.00	−52	.....	....
Special duty nurse (daily rate)	7.36	6.77	9	5.55	33
COSTS					
Overall operating cost per patient day (not including depreciation)	8.64	7.49	15	5.17	45
PAYMENTS					
By city, county or state agencies for indigent patients (daily rate)	4.93	.....	....	.....	....
Compensation cases (daily rate)	5.36	.....	....	.....	....
Blue Cross (daily rate)	5.92	.....	....	.....	....

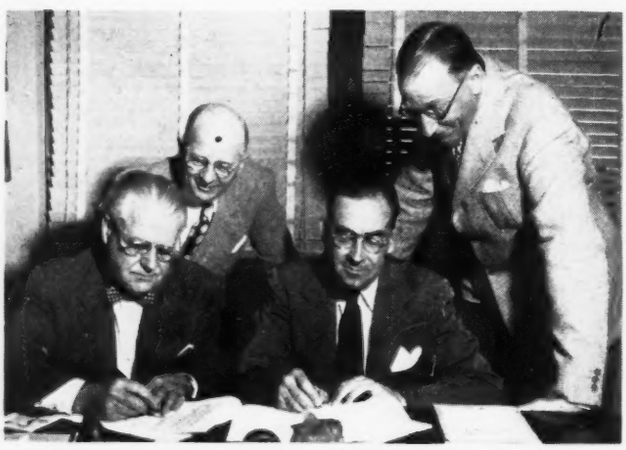
*Figures are averages for all hospitals reporting.

PEOPLE IN PICTURES

The first baby born under Associated Hospital Service, New York's Blue Cross plan, dropped in for a chat recently with Louis H. Pink on the plan's twelfth anniversary.

Col. Florence A. Blanchfield, superintendent of army nurses, first woman commissioned in the regular army, receives her commission from General Eisenhower.

Mayor William O'Dwyer of New York City is commended by a delegation of officers from the Greater New York Hospital Association on his recent action in raising rates for city patients in voluntary hospital wards to $6 per day. Left to right are: Louis Schenkweiler, first vice president; Dr. John V. Connorton, executive secretary; Rev. J. J. Curry, second vice president; Mayor O'Dwyer; Dr. Edward M. Bernecker, commissioner of hospitals; Murray Sargent, association president; Louis Miller, treasurer, and F. Wilson Keller, secretary.



Joseph H. Himes (left), president of Group Hospitalization, Inc., of Washington, D. C., and Dr. Frank D. Costenbader, president of Medical Services of the District of Columbia, sign the contract completing arrangements to offer surgical and obstetrical service to G.H.I. members. Watching are Theodore Wiprud, secretary of Medical Services, and Dr. Walter A. Bloedorn, the secretary of G.H.I.

A gas fired flame photometer is operated by a technician at New England Deaconess Hospital, Boston. This is a new development which permits rapid accurate analysis of sodium, potassium, calcium and lithium. A gas-air premixing apparatus is visible below the table in the right foreground.

Blue Cross Patients Do Not Abuse Their Privileges

A study of services and charges to Blue Cross and non-Blue Cross patients

FRANK R. SHANK
Assistant Superintendent
University of Chicago Clinics
Chicago

THIS study of 1000 Blue Cross patients and 1000 non-Blue Cross patients was made to compare the extent to which each group uses hospital facilities and services and to throw light on the oft discussed question as to whether the fact that a patient carries Blue Cross hospital insurance encourages an earlier use of hospital facilities and, once he is in the hospital, more special services. In other words, will the Blue Cross patient come to the hospital sooner, and stay longer, than does the non-insured patient by virtue of having Blue Cross coverage? The diagnoses of all 2000 cases were analyzed to determine if Blue Cross patients were admitted with petty or minor complaints in more instances than were non-Blue Cross patients.

The 1000 non-Blue Cross cases were selected from records in Albert Merritt Billings Hospital, Chicago, which were closed during the year ending June 30, 1945. Only full pay patients were selected.

The 1000 Blue Cross cases were accumulated over a period of one and a half years ending June 30, 1946. These cases were also taken from the records of the Billings Hospital and the data were taken directly from the statements sent to the Chicago Blue Cross plan.

Of the total number of patients admitted, 55.1 per cent of the Blue Cross cases were ward patients, 20.2 per cent were semiprivate and 24.7 per cent were private patients. Ward patients were those who occupied four bed rooms; semiprivate patients occupied two bed rooms, and private patients occupied single bed rooms. Of the non-Blue Cross cases, 67.8 per cent were ward patients, 16.8 per cent, semiprivate patients and 15.4 per cent, private patients.

These figures indicate that the Blue Cross patients used 12.7 per cent fewer ward beds, 3.4 per cent more semiprivate and 9.3 per cent more private beds than did the non-Blue Cross patients (table 1). That is, a greater proportion of higher priced accommodations was taken by Blue Cross patients who desired to pay an additional cost over the insurance coverage for this privilege.

Table 2 presents a comparison of the days of service used by each of the two groups of patients. The totals were 10,697 patient days for Blue Cross patients and 14,487 patient days for non-Blue Cross patients. This table also indicates that 57.7 per cent of the Blue Cross patient days were spent in ward beds, 17.1 per cent, in semiprivate beds and 25.2 per cent, in private beds. As for the non-Blue Cross patient days, 70.8 per cent were spent in ward beds, 11.6 per cent, in semiprivate beds, 17.6 per cent, in private beds.

Table 3 shows that the average length of stay for Blue Cross patients was 10.70 days, and for the non-Blue Cross patient it was 14.49 days. On the average, the non-Blue Cross ward patient stayed 3.88 days, or 34.5 per cent longer than did the Blue Cross ward patient. The non-Blue Cross private patient stayed 5.59 days longer than did the Blue Cross patient.

One reason for the shorter stay for the Blue Cross patient is that he comes in earlier and does not need to stay so long for recovery. Another reason is that drugs, such as the sulfonamides, penicillin and others,

Table 1—Division of Admissions Into Types of Beds

	Total	Ward	Semi-Private	Private
Blue Cross admissions	1000	551	202	247
per cent of total	100.0	55.1	20.2	24.7
Non-Blue Cross admissions	1000	678	168	154
per cent of total	100.0	67.8	16.8	15.4

Table 2—Division of Admissions Into Patient Days

	Total	Ward	Semi-Private	Private
Blue Cross patient days	10,697	6,174	1,827	2,696
per cent of total	100.0	57.7	17.1	25.6
Non-Blue Cross patient days	14,487	10,261	1,679	2,542
per cent of total	100.0	70.8	11.6	17.7

Table 3—Average Length of Stay in Hospital

	Total	Ward	Semi-Private	Private
Blue Cross:				
Patients	1000	551	202	247
Days of service	10,697	6,174	1,827	2,696
Average length of stay	10.70	11.25	9.05	10.91
Non-Blue Cross:				
Patients	1000	678	168	154
Days of service	14,487	10,261	1,679	2,547
Average length of stay	14.49	15.13	9.99	16.5

Table 4—Comparison of Blue Cross and Non-Blue Cross Patients According to Length of Hospital Stay

No. of Days of Hospitalization	*Totals*	*Per Cent*
Blue Cross		
No. of Patients:		
1-2 inclusive	147	14.7
3-7 inclusive	288	28.8
8-14 inclusive	285	28.5
Over 14	280	28.0
	1000	100.0
Non-Blue Cross		
No. of Patients:		
1-2 inclusive	105	10.5
3-7 inclusive	323	32.3
8-14 inclusive	233	23.3
Over 14	339	33.9
	1000	100.0

Table 5—A Comparison of Blue Cross and Non-Blue Cross Patients as to Admission Diagnoses and Average Length of Stay

	Admitting Diagnoses		*Average Length of Stay—Days*	
	Blue Cross	*Non-Blue Cross*	*Blue Cross*	*Non-Blue Cross*
MEDICAL				
Chest				
Tuberculosis	6	10	8.3	25.4
Cancer of lung	8	7	11.8	30.1
Cardiac and Vascular Disease				
Heart failure	14	11	20.8	14.5
Hypertensive	23	14	11.0	13.0
Gastro-Intestinal				
Peptic ulcer	54	42	12.9	15.7
Liver disease and jaundice	20	13	11.8	26.4
Ca: (a) stomach	15	24	17.0	15.5
(b) colon	10	26	15.4	25.5
Metabolism and Endocrines				
Diabetes	19	18	10.5	14.6
Infectious Diseases				
Pneumonia	5	5	15.0	14.6
Hematology				
Hodgkins disease	14	24	9.7	9.5
SURGICAL				
General Surgery				
Cholecystectomy	24	20	11.0	13.1
Hernia	26	30	10.7	13.0
Hemorrhoids	26	31	6.0	6.3
Varicose veins	14	14	5.0	9.0
Eye				
Cataract	5	11	12.2	17.9
Ear, Nose and Throat				
Tonsillectomy	6	17	1.1	2.6
Urology				
Calculi	16	15	7.0	11.4
Orthopedic				
Osteomyelitis	11	12	9.9	11.4
OBSERVATION AND DEFERRED	77	88	11.2	17.2

Source: Diagnoses from patients' charts in Billings Hospital record room. Length of stay from Blue Cross statements and business office records in the Billings Hospital.

Table 6—Admissions for Conditions Classified as Elective

	No. of Blue Cross Admissions	*No. of Non-Blue Cross Admissions*
Hernia	26	30
Hemorrhoids	26	31
Varicose veins	14	14
Breast surgery, other	13	7
Deviated nasal septum	9	6
Tonsillitis	6	17
Nasal polyps	12	8
	106	113

were being used more extensively during the period for which the records of Blue Cross patients were taken in this study.

Table 4 shows that about the same number of Blue Cross patients stayed for periods of from three to seven days, eight to fourteen days and more than fourteen days, while the non-Blue Cross patients had about an equal number for the periods of from three to seven days and more than fourteen days but the period from eight to fourteen days was about one third less. The smallest number of patients seemed to be in the first two days for both Blue Cross and non-Blue Cross patients.

Table 4 also presents data as to the number and percentage of patients who stayed for certain lengths of time. Of the 1000 Blue Cross patients, 14.7 per cent remained one to two days, whereas 10.5 per cent of non-Blue Cross patients were in this group. The proportion of patients distributed in the three to seven, eight to fourteen and more than fourteen day stays bears out the noted tendency of non-Blue Cross patients to stay in the hospital longer than Blue Cross patients do.

In order to know why patients were admitted to the hospital I obtained the admission diagnoses for the 2000 patients and incorporated this information in Table 5*. These diagnoses were divided into two main headings: medical and surgical. Under "medical" the following subheadings were listed: chest, cardiac and vascular disease, gastro-intestinal, arthritis, metabolism and endocrines, infectious diseases, dermatologic diseases, nephritis, neurological diseases, hematology, psychiatry and allergy. Under the "surgical" heading the following were listed: general surgery, eye, ear, nose and throat, urology and orthopedic.

Table 5 shows the average length of stay for a number of specific diagnoses within these classifications. In the original study records were analyzed for more than 120 separate diagnoses; the selection shown in table 5 includes those in which there was a large enough number of patients in both the Blue Cross and non-Blue Cross groups to assure some degree of comparability.

*Dr. D. Wesley Eisele, associate professor and secretary to the department of medicine at the University of Chicago Clinics, gave valuable assistance by classifying and grouping the diagnoses as shown in table 5.

Table 7—Charges for Extra Services Among Blue Cross and Non-Blue Cross Patients

Service	Blue Cross		Non-Blue Cross	
	No. of Pts. Charged	Amt. Charged Per Diem	No. of Pts. Charged	Amt. Charged Per Diem
Drugs and solutions	730	$1.41	745	$0.79
Operating room and transfusions	483	1.10	543	.97
Electrocardiograph	171	.12	184	.08
Basal metabolism	66	.04	83	.04
Blood bank	84	.39	203	.18
X-ray examination	483	.66	525	.65
Oxygen	30	.06	50	.05
Physical therapy	32	.06	14	.02
Cystoscopy	14	.01	27	.01

Table 5 also supports the earlier evidence that non-Blue Cross patients tend to stay in the hospital longer than do Blue Cross patients.

Among the cases as a whole, no clear cut line could be drawn between what might be considered (1) emergency, (2) needing hospitalization but not emergency and (3) elective hospitalization. It was possible, however, to segregate a few diagnoses as probably elective and these admissions are listed in table 6.

It will be noticed from the tabulation of the number of these admissions that there were 106 Blue Cross patients and 113 non-Blue Cross patients. This would seem to indicate that Blue Cross subscribers are not taking undue advantage of hospital insurance in order to obtain service for more than the ordinary number of elective operations and treatments.

The remaining sections in the study present data on the kinds of special services used by patients and the extent to which they were used. The same system of charges prevailed for both groups.

Table 7 shows that the Blue Cross patients paid more for drugs and intravenous solutions than did the non-Blue Cross patients. The difference amounted to 1.78 times the non-Blue Cross charges per day. Prior to April 1945, penicillin was considered to be more or less in the experimental stage and its use was restricted, but following this period it was more readily available for treatment. The increased use of penicillin increased the cost of drugs considerably and may account for part of the difference in drug costs shown here. However, no special study was made of the amount of penicillin, sulfa or any other specific drugs used. The total drug charges for ward, semiprivate and private patients were higher for Blue Cross patients in all cases.

Table 7 also indicates that operating room and transfusion service was used about equally by Blue Cross and non-Blue Cross patients.

Electrocardiograph and basal metabolism charges show little difference between Blue Cross and non-Blue Cross patients. The blood bank figures suggest that the percentage of Blue Cross patients using the blood bank was smaller than the percentage of non-Blue Cross patients, but the per diem charge, or cost to patient, was about twice as high as the non-Blue Cross charge. This was due to failure of the Blue Cross patients to supply the necessary number of blood donors.

A study of charges for x-ray examination, oxygen and cystoscopy will divulge the fact that about the same percentage of use was made by both Blue Cross and non-Blue Cross patients. These figures also disclose that the per diem charges in all instances are quite comparable. With perhaps the exception of x-ray, the number making use of these hospital services is rather small. The service involving the greatest number of patients is x-ray, with 483 for Blue Cross patients and 525 for non-Blue Cross patients.

It will be observed, however, that Blue Cross patients made greater use of physical therapy than did the non-Blue Cross patients. In this connection, it must be remembered that the Blue Cross cases studied were taken from records one half to one year later than the study for the non-Blue Cross cases, and doctors and surgeons may have utilized the physical therapy department more readily in the later period.

The complete study also included an analysis of charges for a number of other services. However, those listed in table 7 were the most frequently used. No significant variations between Blue Cross and non-Blue Cross patients appeared in any of the other services.

Table 8 lists all extras and per diem charges in summary form for each classification of patient and days of hospitalization. It can be seen that the per diem charge for extras is more for the Blue Cross patient in every instance. In some groupings the difference is very slight while in other groupings it is considerable.

The Blue Cross patient was charged on the whole 32.7 per cent more per day for all extras than the non-Blue Cross patient paid. It must be remembered that the Blue Cross patients stayed 39.1 per cent fewer days than did the non-Blue Cross patients, so that in the final analysis the 39.1 per cent fewer Blue Cross patient days will partially, if not wholly, offset the increased drug charge per day.

Table 8—Extra Charges Per Day for Ward, Semiprivate and Private Patients

Days of Hospitalization		Extra Charges Per Day		
		Ward	Semiprivate	Private
1-2	†	$5.30	$5.82	$9.98
	*	6.36	6.17	12.32
3-7	†	3.92	3.51	5.34
	*	3.28	3.43	5.23
8-14	†	3.37	3.03	4.69
	*	2.48	2.42	4.81
Over 14	†	3.42	3.07	3.66
	*	2.26	2.53	3.58
Average	†	$3.50	$3.22	$4.30
	*	2.43	2.77	3.98
Grand Average	†	$3.65		
	*	2.75		

†Blue Cross Patients
*Non-Blue Cross Patients

ABOUT PEOPLE

Administrators

Richard D. Vanderwarker has been named the director of Passavant Memorial Hospital, Chicago, to succeed the late **Luther S. Hammond Jr.** For the last year and a half, Mr. Vanderwarker has been manager of the Bellerive Hotel in Kansas City, Mo. A graduate of Cornell University's school of hotel administration in 1933, Mr. Vanderwarker that year joined the staff of the Hotel Sherman in Chicago. He remained with the Sherman for nine years, working through various executive positions to become assistant manager and treasurer of the hotel corporation. In July 1942 he entered service as an officer in the U. S. Naval Reserve. He had four years of active duty in the navy, reaching the rank of lieutenant commander. After leaving the service, Mr. Vanderwarker was resident manager of the Ambassador Hotels in Chicago for several months before going to Kansas City. He is 36 years old, married and has two children.

F. Jane Graves is the new administrator of Women's Hospital, Pasadena, Calif. Miss Graves was head of Alton Memorial Hospital, Alton, Ill., for eleven years and prior to that was associated with Methodist Hospital, Peoria, Ill.

Dr. Edward Kupka, medical director of La Vina Sanatorium, La Vina, Calif., has resigned that position to become medical director of the tuberculosis division of the California State Department of Public Health.

Walter B. Phelps, formerly business manager of the American Legion Hospital, Battle Creek, Mich., on August 15 assumed the duties of administrator of Good Samaritan Hospital, Lexington, Ky.

Gerhard Hartman, superintendent of the University of Iowa Hospitals, Iowa City, has moved up to the presidency of the Iowa Hospital Association. Mr. Hartman, elected vice president at the association's annual convention in April, automatically fills the vacancy left by **Paul Hanson,** superintendent of Iowa Lutheran Hospital, Des Moines, who has accepted the post of administrator of Emanuel Hospital, Portland, Ore.

Donald W. Cordes has been appointed administrator of Iowa Methodist Hospital, Des Moines, succeeding **R. A. Nettleton,** who resigned on August 12. He had been administrator for the last twenty years. Mr. Cordes was named assistant administrator of the institution early this year. Mr. Nettleton is a charter fellow of the American College of Hospital Administrators and a charter member of the Iowa Hospital Association, which he served as president in 1935-36.

Murphy Cole is the new administrator of Anniston Memorial Hospital, Anniston, Ala. Mr. Cole, a graduate of the Northwestern University course in hospital administration, has served on the administrative staff of the Illinois Central Railroad Department of Hospitals and Infirmaries since his discharge from the army in June 1946.

Myrtle B. Crudim, M.D., has been appointed administrator of Hospital Cottages, Baldwinville, Mass. Dr. Crudim had been associated with the Venereal Disease Control Program in Chicago for nine years prior to her coming to Hospital Cottages. She served seven years as assistant director of the clinic section and two years as hospital administrator of the Chicago Intensive Treatment Center. A graduate of Marquette University Medical School, Milwaukee, Dr. Crudim took courses in hospital administration at Northwestern University as a special student. She is a member of A. H. A.

Frank M. Cameron, who recently received his M.S. in hospital administration at Northwestern University, has been appointed assistant to **Merton E. Knisely,** administrator of St. Luke's Hospital, Milwaukee. Mr. Cameron served for four years in the army medical department. During the course of his studies, he served at Children's Memorial Hospital and Grant Hospital in Chicago.

Charles B. Allen, executive director of Springfield City Hospital, Springfield, Ohio, resigned recently to become superintendent of Monmouth Memorial Hospital, Long Branch, N. J. He succeeds **Arkell Cook** who left to direct Garfield Hospital in Washington, D. C. Before going to Springfield Mr. Allen was superintendent of St. Luke's Hospital, Newburgh, N. Y.

Grace V. Barber, formerly superintendent of Women's Hospital of the University of Pittsburgh Medical College, has been selected to head the new Children's Memorial Hospital at Omaha, Neb., which is scheduled for completion January 1.

W. K. Klein, assistant superintendent at the University of Minnesota Hospitals, Minneapolis, has accepted the post of director of Hurley Hospital, Flint, Mich., succeeding **Ralph M. Hueston.** Mr. Klein joined the staff of the University of Minnesota Hospitals in 1942 as director of service and supplies and became assistant superintendent in 1944.

Sterling Shrauger of Pawnee City, Neb., has been named business manager of Pawnee County Hospital, recently purchased from its owner by the Pawnee County commissioners.

Sister M. Siegberta, O.S.F., R.N., superintendent of St. Mary's Hospital, Columbus, Neb., recently celebrated the golden anniversary of her investiture in the Poor Sisters of St. Francis Seraph.

Mitchell M. Waife has been appointed to the newly created office of administrative assistant at Menorah Hospital, Kansas City, Mo. He will be in charge of public relations and personnel.

James V. Devine has been appointed administrative assistant at Malden Hospital, Malden, Mass. He is a graduate of Holy Cross College and has been associated with the hospital since the summer of 1945.

Elwin E. Glover, formerly superintendent, Brooks Hospital, Dunkirk, N. Y., has been named superintendent of the Samaritan Hospital at Troy, N. Y., succeeding **Mrs. Helen L. Warren.**

Paul Fleming has been named to succeed **Mary Jane Hutchinson** as adminis-

(*Continued on Page* 184.)

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We Need *Leadership* in Hospital Affairs

RAYMOND P. SLOAN

What constitutes true hospital leadership? The question raised in this article will be answered in forthcoming issues by a series of articles based on the contributions of certain American citizens toward establishing regional and national patterns of hospital and health care — men, and women too, who have demonstrated their abilities as true hospital leaders

HOSPITAL and health service, the greatest public utility in this country today, remains singularly lacking in leadership. It lacks the elements of wise counsel, imagination and intelligent overall planning that are essential to provide every man, woman and child with the highest type of health care at the lowest possible cost. This unassailable fact becomes the more difficult to explain in view of the great talents and power revealed on the boards of our voluntary hospitals. From a field of leaders representing practically every walk of life comparatively few have assumed responsibility for hospital care on any broad scale.

The only answer seems to be that little has been done to impress upon our potential spokesmen the basic importance of health to the future of the nation and the part played in it by the modern hospital.

What leadership has exerted itself in hospital affairs in the past has been measured too often by one individual's contributions to a single hospital, contributions made in the form of time, money and sometimes both. Hospitals have been a medium for philanthropy and their sponsors have been philanthropists first and leaders of health and social movements second. These men for the most part have thought and planned in terms of a single institution, motivated by individual interests rather than in terms of community or national health and medical care.

In fairness it should be explained, that this is predicated on the days before hospitals and public health played such an important part in community planning as they do today. Each unit of service was then judged by its individual accomplishments and prestige rather than by the value of its contribution to an overall pattern. Furthermore, there was little knowledge on the part of the average trustee of his precise functions and the complexities of hospital operation.

We now recognize that "to sit" on the board of a hospital no longer describes adequately the obligations of the trustee. If this individual has assumed his hospital obligations sitting down rather than standing up, it is because he has never been informed what he should stand up to. To this serious oversight may be attributed the lack of any overall hospital system in this country today. It is only within the past few years that trustees have begun to learn.

When the desire for knowledge exists, ignorance can easily be overcome. The questions are: have we that desire; if not, what can be done to develop it, and what constitutes true leadership in hospital affairs?

To promote a desire for leadership we must make the cause and its end results worthy of the efforts expended. There must be definite challenge.

If this is true, there should be no difficulty in attracting competent leadership to the hospital field. What better end results could we have to fight for than the health of the nation, conquering the many dread diseases to which men, women and children are falling victims daily? There is definite challenge, as well, in the preservation of the voluntary system which has brought hospital service to its present high attainments but which lies in the balance today.

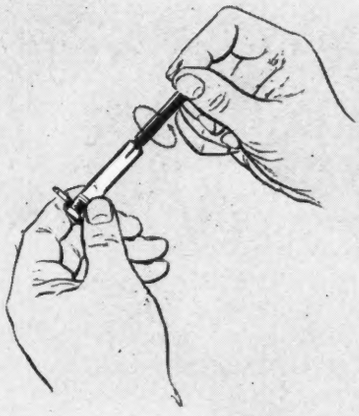
Hospitals, moreover, constitute big business. They represent a total purchasing volume of more than a billion dollars annually. They feed one and a half million patients and a million employes every day at standards comparable with those of a good hotel. Their raw food bills alone total nearly half a billion dollars a year. They operate laundries comparable in size with commercial laundries in their communities. The capital investment in their properties reaches staggering proportions and it is estimated that the accumulated need for new and replacement hospital facilities at this time totals almost four and a half billion dollars. Who will say that this is not the language of big business and that as custodians for the vast sums held in trust we haven't need of leadership?

Upon the quality of hospital leadership exercised during the next few years will depend the quality of hospital and medical care that the American public may expect in the future. It is a question whether such leadership will come voluntarily from the ranks of those public spirited citizens who without thought of personal advancement are seeking to perpetuate a hospital system free from government control, or whether our hospital policies will be established in Washington.

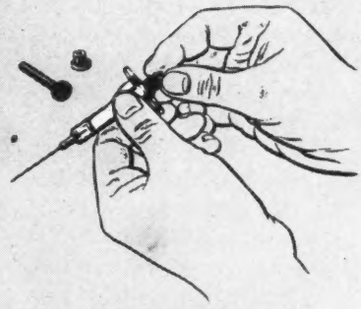
We have every reason to look for such leadership among the ranks of public servants who now are serving on voluntary hospital boards throughout the country. Their knowledge of certain basic problems of hospital care should enable them to understand better the broader issues which must be met. This need not necessarily debar others, however, who through unselfish interest in public affairs may possess the vision and the competency to step in and provide direction.

Hospital leadership must obviously start at the community level and from that point develop to state and national importance. It will manifest itself first through hospital and public health planning for a specific community, assuring a definite pat-

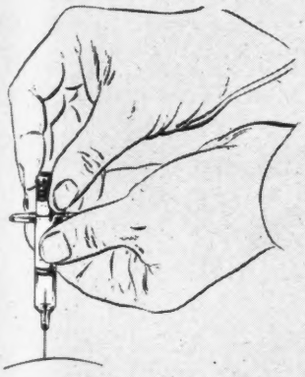
Real Convenience in Penicillin Therapy



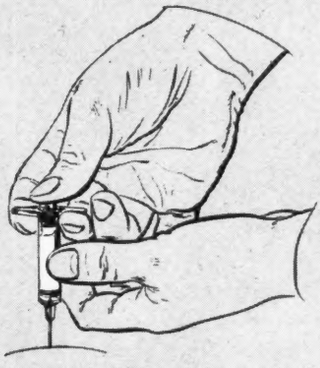
1 The protective needle sheath is removed by a twisting motion, exposing the sterile 20-gauge needle. The sheath also serves as the syringe plunger.



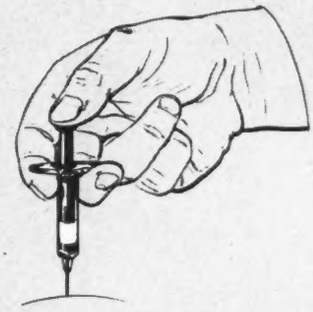
2 Diaphragm end of cartridge is then dipped in an antiseptic solution and cartridge is inserted into syringe barrel just to point of inner needle.



3 Needle is now inserted into muscle into which injection is to be made and cartridge is withdrawn slightly to determine if needle end is in a vein.



4 If vein has not been entered, cartridge is forced into end of barrel lumen, causing inner needle to pierce cartridge diaphragm and to establish communication with the oil and wax mixture.



5 Plunger (needle sheath) is now inserted into cartridge. Pressure on end of plunger serves to expel contents of cartridge into muscle or subcutaneous tissue.

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tern by which every citizen of that community may expect adequate and proper health care.

We see what proper leadership in this direction has accomplished already and can accomplish through regionalization of hospital services. In certain communities a group of formerly unrelated and poorly equipped hospitals is now welded into a strong chain of modern medical and hospital units, supplementing one another successfully in their various services and, in addition, providing educational opportunities for doctors, nurses and other professional workers.

We see the same trend toward new hospital thinking and planning in the recent two year study undertaken by the Commission on Hospital Care. It was the function of this group to make a comprehensive study of hospital and health care facilities throughout the United States for the purpose of recommending a plan for the development of a coordinated national hospital service.

Same Trend in Urban Centers

We see the same trend in hospital planning for large metropolitan centers exemplified in extensive studies made by the planning committee of the Hospital Council of Greater New York in presenting a pattern to assure every section of that city adequate hospital care without duplication of services. The time has passed when hospitals, like Topsy, merely grew. Today they grow to an amazing degree but within the confines of overall planning.

Such examples of intelligent planning are sufficient to indicate what sound leadership can accomplish in creating a pattern. Granted that we have the pattern, however, we still need leadership in building to that pattern.

It has already been pointed out that hospital leadership may well start at the community level. There can be no better medium for studying and reorganizing hospital work on a community basis than through the formation of local hospital councils. Such groups comprising presidents of boards, administrators and such public health officials as seems expedient, meeting at regular intervals to discuss mutual problems are definitely steps in the right direction. But they must have leaders.

If we assume that the president of a hospital through attendance at hospital council meetings becomes cognizant of the various problems that present themselves, the question remains how this knowledge can be shared by the rest of the board. One suggestion is to hold community or regional trustee institutes with programs carefully selected to bring the average board member up to date on hospital developments, to broaden his knowledge and to encourage him to play a more active part in hospital affairs.

From local activities it is not a great step to state activities. Here, administrators working in conjunction with trustees will form a team that is destined to shape the future of our hospitals. Action taken recently by one state hospital association in electing a hospital trustee to its vice presidency would seem to be significant. How else can we develop public interest and support for our hospitals than by working closely together, professional hospital people and representatives of the public?

Hospital trustees should be encouraged to follow more closely the activities of their local and state hospital associations. By so doing they will learn. These bodies in turn should afford the trustee opportunities to develop his powers of leadership.

We have definite need for leadership in influencing local and national legislation affecting our hospitals. Whereas the voice of the trustee should count for much, it seldom if ever is heard unless particular pressure is brought to bear upon him to express his objection or approval. Too frequently unfavorable, even dangerous, laws are passed without the trustees' knowledge. Challenges to the voluntary hospital system of this country are being made almost daily which require the best brains and talents possible. Many hospital boards have an abundance of both; they need only be made available.

Fund raising projects provide additional opportunities for the trustee to reveal his potentialities as a leader. The success or failure of such development programs rests to a large extent, it has been proved, upon the leadership exerted by citizens of the community, whether or not they happen to be trustees. The knowledge gained through rehearsing the hospital story and relating it to others provides excellent training for leadership. The individual thus becomes virtually a salesman for the hospital.

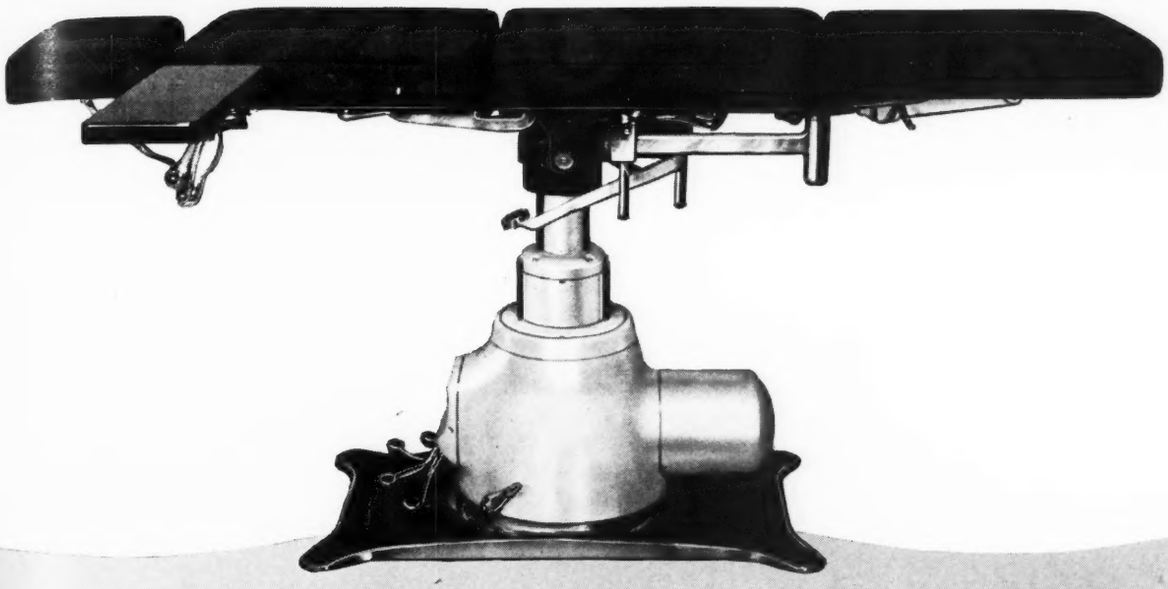
Having developed hospital interest and leadership starting on a community level to and through a state level, we now proceed to the final step. Reference has previously been made to the tremendous contribution made by the Commission on Hospital Care in which a group of professional workers, prominent laymen and social agency workers, with the assistance of hospital studies provided by the various states, formulated a pattern for coordinated national hospital service. Having been shown the way, our present need is for suitable leadership to direct us along paths that will lead to the desired goal. It is vital that we not overlook the broad picture of hospital service on a national basis.

Trustees Should Participate

Through the sponsorship of the American Hospital Association various projects have been inaugurated looking toward the advancement of hospital service in this country. It is to be hoped that greater opportunity for participation in its affairs will be provided for trustees and other public health and social agency workers to assure broader interpretation of hospital policies and closer integration of hospital services with other public health projects. If the pattern as formulated by the Commission on Hospital Care appears sound and logical why not the appointment of some continuing body with the same diversification of interests represented?

Similarly, why should not the names of certain hospital trustees appear on various committees of the American Hospital Association? Why should such names not appear among its officers and directors?

If we would be assured of true leadership we have need to nourish it, to give it a chance to grow. To accomplish our aims it is necessary to divert the interest and attention of laymen from individual planning and thought to central planning and thought, to broaden their horizons, to cause them to make personal sacrifies, if necessary, to realize an all-embracive hospital program that will serve the many rather than the few.



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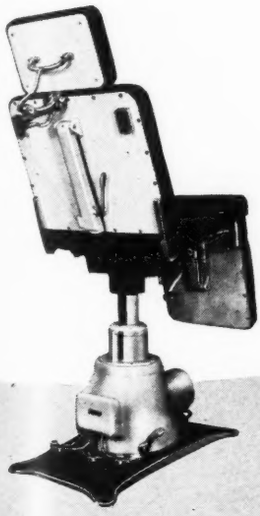

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Standardizing for Smooth Teamwork in the Operating Room

B. ETSTEN, M.D.
J. C. McCLINTOCK, M.D.
E. H. CAMPBELL, M.D.
Albany Hospital, Albany, N. Y.

THE success of standardizing equipment and procedures in an operating room depends upon the cooperation of the surgeons, anesthesiologists, nurses and administration.

The surgeons are best qualified to determine the requirements for instruments and for their working materials essential to the various surgical procedures. The nursing staff can evaluate the labor and time needed for the collection, sterilization and preparation of instruments, drapes and sponges for the various operations. The anesthesiologists are cognizant of all the functions associated with the nursing staff and surgery. They are in the most suitable position to determine the efficiency of the various operating room tables and lights and, also, can more effectively correlate and organize the working functions of the operating room.

Teamwork for Better Care

The administration can best evaluate the combined recommendations of these staffs as to practicality and economy. Such teamwork in standardization decreases the load of work for the nurses, enhances the working conditions for the surgeons and increases the efficiency of the operating room. The most important feature is that it provides better and safer care for a greater number of patients.

During 1946, the surgeon-in-chief of Albany Hospital, Albany, N. Y., appointed an operating room committee charged with the responsibility of investigating and recommending any improvements that would increase the efficiency of the operating room. This committee was composed of the chief anesthesiologist and three surgeons.

The ensuing discussion is based upon the experiences of this committee, which adopted the following plan as a working guide:

1. Investigation of operating room equipment and procedures in this and other hospitals.
2. Consultations with the individual surgeons, surgeon-in-chief and administration.
3. Final recommendations to the surgical staff.
4. Approved recommendations to be referred to the administration by the surgeon-in-chief.

The committee discovered that 53 doctors have full surgical privileges in our hospital. Most of these surgeons owned their own instruments. This resulted in an accumulation of varied types of instruments, some of practical value and others irreparable and outdated. For example, there were found to be at least seven different styles of 5½ straight, and a large assortment of curved, hemostats. It was found that a great deal of nursing time was lost, because: (1) the nurses often had to borrow from one surgeon's supply to complete an instrument set for another surgeon and (2) the nurses had to sort each surgeon's instruments and place them in their respective cabinets after each surgical procedure.

The committee's problem was made more difficult by the fact that 7500 surgical procedures were performed in eight operating rooms in which many different types of lights, sterilizers and operating tables were used. These findings led to the following recommendations to the surgical staff.

1. That the hospital assume ownership of all instruments. The staff was consulted and advised of the advantages of such ownership.
2. That the committee study and investigate the necessity of purchasing new operating tables, lights and sterilizers; that all new equipment be one type so that there could be an interchangeability of parts which would also predispose to better maintenance.

Although the aims of the committee are to produce a uniformity of procedures and instruments, it was fully realized that complete standardization is not advisable because surgical technics will vary with the individual surgeon, which in no way reflects upon the ability of the surgeon or the end result to the patient. However, the variations in technics do not require the use of a large number of varied types of instruments and procedures.

Hospital Owns Instruments

These recommendations were accepted by the surgical staff. The surgeon-in-chief and the gynecologist-in-chief endorsed and referred them to the administration. The hospital has now assumed ownership of the surgical instruments donated by the members of the department of surgery. The purchase of new instruments and the maintenance of the old are now managed by the operating room committee.

Further investigation by the committee revealed that basic instrument sets for the operative procedures rather than for the individual surgeon would facilitate the setting up of cases in the morning and reduce the time interval between cases. Again, the surgeons were interrogated as to their opinions concerning the necessary numbers and style of instruments for a laparotomy, with the addition of other instruments for the special surgical procedure. Sample lists were sent to the surgeons and returned to the committee. The expressed desire of the majority was embodied in the basic set agreed upon. The standard set

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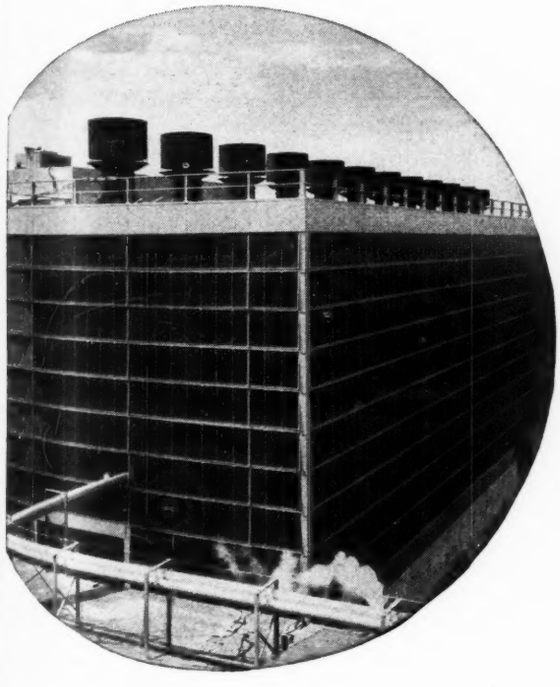

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for a laparotomy with certain instruments to be added according to the special operative procedure was presented and adopted by the members of the surgical staff.

The committee, thus acting as a liaison among the nursing staff, surgeons and administration, has been able to formulate smooth teamwork. By means of the methods described, equipment has been standardized, more efficient material is used, nursing time is saved and more operative procedures can be performed with a maximum of safety.

Don't Take the Pharmacy for Granted

HANS HANSEN
Pharmacist
Grant Hospital
Chicago

WHY is pharmacy the forgotten professional department of the hospital? If we except food and clothing nothing man uses for his health and comfort is older than drugs. Prehistoric man used drugs on an empirical basis, and as he developed and civilization became more complicated, so his use of drugs developed and this use became more complicated until today pharmacology is a great science in its own right.

Some time ago the public relations department of one of our large Chicago hospitals published a splendid informative article on the hospital. Each department was described, its importance to the patient, staff and hospital was noted. Not one word was said about the pharmacy department, a department that is headed by a competent pharmacist and staffed with several well trained pharmacists and chemists, a department that is used more frequently than is any other by the patient, the staff member, the intern, the nurse and the student nurse.

They Never Heard of Pharmacy

In my own hospital, at our last graduation class, the president of the medical staff called the attention of the graduates to the privileges they had enjoyed and profited by during their period of training, the beautiful nursing residence that had been their home, the surgical and O.B. departments, the laboratory, the x-ray and outpatient departments. He told them about the housekeeping, dietary and laundry departments, finishing with the engineering department that had produced an abundance of steam and hot water. But not one word did he say of the pharmacy.

Not all patients admitted to the hospital go to surgery or x-ray, but every day of their stay, directly or indirectly, they receive pharmaceutical service. Maybe the answer is that we take drugs, pharmacy and pharmaceuticals for granted because they have been a part of us from time immemorial. But we should never take anything for granted; it has proved time and again to be dangerous.

Rational therapeutics has almost entirely replaced therapeutics based on empiricism, but not so completely has the modern pharmacy in hospitals replaced the old drug room. There is a distinction. A drug room is just a room where drugs are stored, presided over by a medical intern or a nurse and, I am sorry to say, sometimes by a pharmacist, while a pharmacy is a place where drugs and pharmaceuticals are compounded and dispensed by a registered pharmacist or pharmacists. A physician who practices in a hospital with a drug room has his therapy limited to the stock of pills, tablets and liquids on hand. The physician who practices in a hospital with a modern pharmacy has the advantage of help and cooperation in this therapy.

The greater need for better pharmaceutical service in the hospital began early in the present century. This was coincidental with the beginning of medical research as we know it today. Gradually it has developed, from the efforts of the lone investigators attacking their problem with an associate or two, into nationwide cooperative and coordinated work. Using the services of the organic chemist, biochemist, bacteriologist and many others, as well as clinical laboratories, research has brought us better drugs to cure man's ills.

The physician of today must cope with thousands of drugs where his predecessor coped with hundreds. This fact is bringing about a gradual change in medical practice. What does this mean to the hospital? It means the hospital must give better pharmaceutical service. This it can do if it has a pharmacy department that can accept its greater responsibilities and measure up to its increased importance. Over and above the responsibility of selecting and buying the best sulfonamides and antibiotics available, there are two other factors that must be considered, neither of which is, in a sense, new. Both have increased in importance, however, with the advances in chemotherapy. I refer to the storage, care and preparation of these agents and the dissemination of information concerning them.

Price Is Last Consideration

The purchasing of these items should not be different from that for the simplest pharmaceutical preparation. Price should be the last consideration. Too often, it plays too important a rôle when human welfare and life are in the balance.

Even the simplest pharmaceuticals should be considered important enough to receive the best attention. However, most are sturdy and stable —not so the antibiotics. These are very tricky and their effectiveness is easily destroyed by contamination so that great care must be exercised in their preparation and storage.

Now as to the dissemination of information concerning chemothera-

From a paper presented at the Tri-State Hospital Assembly, May 1947.

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peutic agents. Again, the pharmacy department should always be able to give pharmaceutical and pharmacological information. I mentioned previously that the physician of today copes with thousands of preparations, and it is almost a physical impossibility for him to keep abreast of new developments. The pharmacist should abstract the literature and maintain a file on new drugs. This should not be done solely on a scientific plane; the pharmacist should also have available all commercial product information, such as types and dosage forms obtainable.

How the Department Serves

I have mentioned in a general way the service the pharmacy department must render because of the advances in chemotherapy. Now to show by a few illustrations the practical application of these generalizations. Before the now common dosage forms were made available by the various pharmaceutical manufacturers, many hospitals supplied them through the efforts of their pharmacists. Oral liquid preparations, ointments and troches of penicillin were either prepared by formulas they themselves developed, or were based on information obtained from scientific publications.

Sometimes it is as important to furnish the physician with the reasons a preparation cannot be supplied as it is to supply it. He is then satisfied that he has not overlooked any possibilities in therapy.

The physician should also be informed as to the uselessness of certain forms of antibiotic preparations. I have in mind eye drops of penicillin; unless such a preparation is dropped into the eye every two minutes it is of no value. The medication is washed away too rapidly to be effective.

The pharmacy department cannot be expected to offer this high type of pharmaceutical service if it is understaffed, if it is not supplied with an up to date pharmaceutical library and all other necessary equipment. In this change in medical practice brought about by advances in chemotherapy, as well as other therapy advances, the hospital pharmacist should be ready to assume greater responsibilities. But these are joint responsibilities and the hospital administration must be willing to assume its share.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

Digitalis

WHEN Withering in 1785 introduced foxglove for the treatment of ascites he was well aware that he was dealing with a drug of great potency and that "it seemed necessary to bring the doses of it to the greatest possible accuracy." He was also cognizant of the variability of the activity of the leaves and discarded using a decoction in favor of an infusion because he felt that the long boiling might destroy the activity of the leaf. As a further safeguard against loss of potency he employed and advocated the use of the "leaves in powder."

Because at this time the use of "insects and quadrupeds" for the study of drugs "had not been much attended to" he was forced to learn the virtues of the drug "from empirical usages and experience of the populace." He knew that the beneficial effects "do not at all depend upon its exciting nausea or vomiting" and that "if the medicine purges it is almost certain to fail in its desired effects."

Thus, Withering was mindful of the need of animal standardization of digitalis, and since standardization in animals was not then possible, he resorted to human standardization, well aware that it was not necessary and was even detrimental to induce toxic symptoms. Undoubtedly a closer study of his original article would have prevented much of the confusion and inaccuracies introduced by later workers.

Preparation. One is utterly amazed at the large number of digitalis preparations which are now available from commercial sources. For clinical use, only three types of digitalis preparations need be considered. No specific superiority over tincture of digitalis, powdered digitalis leaf and one of the many crystalline glucosides has been demonstrated for any of the more expensive preparations. Without question, digitalis leaf in tablet form is the least expensive of all preparations. One can completely discount any statements which suggest that a product is effective without being toxic inasmuch as the clinical beneficial action of digitalis is, in fact, a minor degree of its basic toxicity and these two degrees of action cannot be separated except by proper dosage.

Of the purified glucosides, cedilanid, digoxin and digitoxin have received the most study. While there is no ultimate difference in the clinical effect of these substances, their rates of absorption from the gastrointestinal canal, rapidity of action and ease of maintaining digitalization are of distinct importance. As a general pharmacological rule, the more rapid the onset of action, the shorter the duration of action. According to Cattell and Gold of Cornell University, no demonstrable difference in ratio of therapeutic to toxic dose of any of the glucosides is found in the experimental animal. The report of Moe and Visscher of Minnesota stimulated considerable work on Digitalis lanata glucosides. From the large amount of literature concerning lanatosid C one may conclude that it is a rapidly acting, potent substance. From the great difference in the oral and intravenous dose it is suggested that absorption is poor, and from the spread of oral dosage necessary to effect digitalization it is further evident that absorption is variable.

Digoxin is a potent purified glucoside prepared by hydrolysis of lanatosid C. Like its parent substance it is rapid in action; however, it is more rapidly eliminated. Batterman and DeGraff of New York found that about half of any given dose of digoxin is eliminated in twenty-four hours and, further, that an effective single digitalizing dose became ineffective if given in divided portions over a twenty-four hour period. It is less soluble and more irritating than lanatosid C and comparably the

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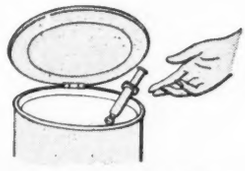

3. ***Then throw the whole syringe away***

Nothing could be simpler! No tricky parts to sterilize or keep track of. Each syringe is a complete unit . . . *completely* disposable.

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spread of its dosage again suggests variability in absorption.

Digitoxin, although isolated about 80 years ago by Nativelle of France, has just recently become readily available for clinical use. All the characteristic pharmacological actions of digitalis leaf are inherent in digitoxin. While its action is not slower than that of other glucosides its duration of effect is longer, and Gold has found that its absorption from the gastrointestinal tract is reliably complete. Digitoxin is 1000 times as active as the leaf and has the same therapeutic-toxic ratio. An advantage over the leaf is that nausea from irritation of the stomach occurs in only 2 per cent of the cases, while it averages 20 per cent for digitalis leaf. Commercially, digitoxin appears under various trade names, such as Crystodigin, Purodigin, Digitalin Nativelle.

Digitoxin is the drug of choice when a purified preparation is needed because it does not require assay; it is reliably and completely absorbed; it can be used for rapid digitalization by intravenous injection; it can be used for maintenance of digitalization because of its prolonged action, and it produces a minimum of local irritation in the dosage used. Its cost is considerably above that of digitalis leaf.

Standardization. Inasmuch as digitalis is a galenical containing highly active substances in varying quantities, assay is imperative. Chemical procedures have only recently been introduced and have not as yet given unequivocal results. The work of Krantz and his co-workers at Maryland indicates that the Baljet reaction may be eventually suited for chemical assay. Until this method has become definitive, reliance must be placed on bioassay.

One must clearly differentiate between the importance of bioassay and the relative unimportance of units. The dose of digitalis for any given patient is not a fixed one although the majority of patients do react favorably to amounts within rather narrow limits, but the actual dose for any particular patient is that quantity which will effect a maximum beneficial response without producing sustained toxic symptoms.

Bioassay of this drug is directed toward assuring uniformity of products so that no possibility of overdigitalization or underdigitalization need theoretically be considered. The fundamental point is that a preparation of digitalis be equivalent to a reproducible standard, the activity of both the known and unknown being determined by an official acceptable bioassay method.

Thus, all standardized preparations are of equal activity, and one may use any tincture or leaf of United States Pharmacopoeia standard, knowing that the activity is equivalent to any other product so labeled. Inasmuch as the crystalline glucosides are chemically and physically constant they eventually will not need to be assayed biologically once their relative activity to a standard leaf has been established.

Units. The United States Pharmacopoeia requires that each gram of digitalis shall be equivalent to 10 U.S.P. digitalis units, the assayed potency of U.S.P. digitalis reference powder. Because of differences in absorption rate from the lymph sac the frog has been discarded in favor of the cat. But since in this animal the drug is given intravenously, no determination is made of the relative

...tate J. Med. 46:527 (Mar. 1) 1946.
...and McLendon, P. A.: *M. Ann. Dist.*
...W.J.: *The Lancet 1:922 (June 22) 1946.*

rate and degree of absorption from the gastrointestinal tract, an important therapeutic consideration since Gold has shown that preparations with the same "cat unit" strength vary tenfold in human beings.

In view of the fact that *several* glucosides in the leaf are active, it is simplest to assay the total potency in terms of a known like specimen. There is no actual need for the designation "unit." It is essential that the potency of the reference powder be known and readily duplicated, and this can be done most easily by stating that a given quantity administered under given conditions is lethal to one kilogram of cat and hence is equivalent to one unit. It would be just as judicious to say the unknown preparation is equivalent in activity to a weight of digitoxin. The term "unit" is a pharmacological, not a therapeutic, designation of activity not expressible in terms of weight or measure. It may be looked on as a convenience for comparison of potency.

The human method of assay as proposed and carried out by Gold of Cornell University is still in a formative stage. There is no question that this method gives a closer approximation to clinical experience, but it is time consuming, and in the final estimation of changes in the T wave the cardiographer is met with the difficulty of knowing that the changes are due to digitalis alone and not to any other factor, such as myocardial damage.

In summary, it may be stated that the crystalline glucosides are not capable of effecting any changes in the cardiovascular system not produced by digitalis leaf but that their dosage, particularly of the pure glucoside digitoxin, may be defined more accurately. These crystalline glucosides are less likely to effect nausea and vomiting by irritating the stomach and may be given intravenously. Their cost is relatively greater than that of the standardized digitalis leaf.—W. J. R. Camp, M.D.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Geriatric Service

The aged need special medical attention and the best place to obtain it is in a general hospital in which a geriatric service is completely integrated with the other services of the hospital. This is the theme developed by Trevor H. Howell in a thought provoking article, "A Geriatric Service in a General Hospital," published in the November-December 1946 issue of *Geriatrics*.

The author reports that 30 per cent of all admissions to the geriatric service in the general hospital under discussion die shortly in spite of all treatment; 40 per cent recover completely or partially. The remainder undergo little change. This is a considerable improvement on the situation in hospitals which are limited to the care of the aged and the chronic sick. The latter rarely send patients back to their homes while the former take discharge and recovery as commonplace.

Geriatrics embraces almost every medical and surgical disorder known to mankind and involves all specialties, proving further the contention that a geriatric service should be in a general hospital.

A complete geriatric service must include outpatient clinics and wards, and the geriatric specialist must be

Periodic Acne!

The ovaries appear to have a definite but variable influence on the condition of the skin. The effect is upon the sebaceous glands, primarily, and a disturbance in this ovariandermal relationship seems to be responsible for the quite common "periodic acne". The skin eruption comes and goes with the menstrual cycle. Periodic headaches may be associated with the condition.

Ovarian Concentrate Armour has been found to be quite beneficial in this syndrome. This preparation is a special sterol fraction, free from demonstrable estrogenic properties, derived from the fat and lipoid fraction of whole ovaries by a special process originated in the Armour Laboratories. It is put up in sealed gelatin capsules (glanules). The recommended dose for periodic acne is one glanule t. i. d. for one month. After this, one glanule t. i. d. for seven to ten days premenstrually may suffice. They should be taken with meals.

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Ovarian Concentrate Glanules

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THE *Armour* LABORATORIES

HEADQUARTERS FOR MEDICINALS OF ANIMAL ORIGIN • CHICAGO 9, ILLINOIS

ready either to admit a patient or send him back to his family doctor after a few visits. Early admission rather than prolonged investigation in the clinic is recommended.

Certain cases should be segregated. For example, incontinent patients should be kept together in order to localize and prepare for the extra work involved. At the same time, however, there should be a mixing of certain types of cases in order to give more activity to a ward. A bedridden patient seeing an ambulatory patient is given an incentive toward recovery. Nurses should be rotated on the geriatric service so that they do not become stale. However, no stigma should be attached to working on this service and it should be part of the routine of the hospital.

The physical therapy department should play an important part in the geriatric service and the director should review progress periodically and consult with the doctors in the case.

An experienced physician should be in charge of the geriatric service. He should have special knowledge of cardiology, neurology and rheumatic diseases. A surgeon, orthopedist, specialist in physical medicine and other specialists should work in close cooperation with the physician in charge. The young and inexperienced physician should not serve the aged. Prompt treatment is important in the aged since they tend to slip beyond the reach of therapy unless immediate preventive measures are taken. What might be a trivial sign to the novice may be an important sign to the experienced man. No doctor should have more than 100 senile cases and, if complicated research and rehabilitation are going on, this number might be too great. The aged can develop great faith in a doctor, so much so that it can make all the difference in their recovery.—IRVING GOTTSEGEN.

Changes in Methods of Suicide

In the May 1947 issue of the *Statistical Bulletin* issued by the Metropolitan Life Insurance Company there is an informative article about the changes in methods of suicide. We learn that the majority of suicide victims use either firearms, hanging, asphyxiation by gas or poisoning. The proportion of the four leading means of suicide, as a group, to the total has remained practically unchanged in the last twenty-five years, but there have been some marked changes in the relative importance of the individual means. Hanging as a means of self-destruction has increased. Among white males in the period 1921-1925 hanging was used in 17 per cent of the suicides; in 1946 the proportion was 28 per cent. Among white females the percentage rose from about 9 per cent of the total to about 25 per cent and hanging is now their leading mode of suicide.

Poisoning has become much less frequent. Among white males the relative frequency of this means was reduced from 14 per cent in 1921-1925 to 7 per cent in 1946. Among white women poisoning has declined from about one third of the total to about one fifth. Poisoning now ranks second in the list of suicide methods used by women.

We are told that among white men, firearms have continued to be the most frequent means employed, accounting for about one third of all suicides throughout the quarter century under survey. Hanging, in second place, is used in more than a fourth of the deaths; asphyxiation by gas accounted for nearly one sixth of the total. These three methods account for three fourths of all suicides in this group. Poisoning is in fourth place, far below the others. Among white females the methods in order of frequency are hanging, poisoning, asphyxiation by gas and firearms.—JOHN F. CRANE.

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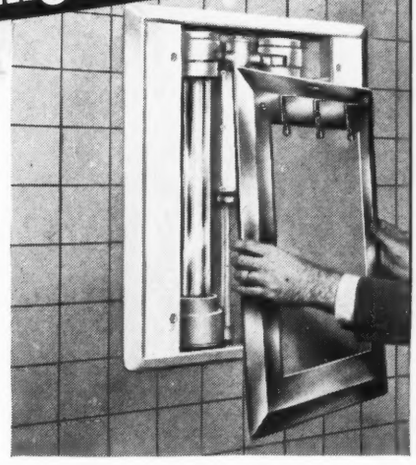

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FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

Frozen Foods

are they here to stay?

JENNIE McINTOSH

Head, Food Economics and Nutrition
Frozen Food Foundation, Syracuse, N. Y.

FROZEN fruits and vegetables were used in many homes and institutions during the war where they never had been used before. There was a tremendous consumer response and the supply available could not meet the demand. This was due to a number of reasons:

1. Frozen fruits and vegetables retain the color and flavor of the fresh product.
2. Canned foods were rationed and in short supply.
3. More homemakers were working outside the home than ever before. Frozen foods are convenient. They made it possible for the homemaker and those in charge of large group food services to prepare attractive, nutritious meals in a short time.
4. The cost of food was not considered so carefully during the war as was true in normal times.

Fewer Frozen Meats

Frozen meats have not as yet been widely distributed. They are packed by a few firms and are available in a limited number of stores.

During the last years of the war, at first gradually and then in a regular torrent, all sorts, descriptions and kinds of frozen prepared foods appeared on the market. This flood probably reached its peak late in 1946 and is now receding.

During the past few months consumers have been guarding their earnings more carefully. They are no longer willing to pay exorbitant prices for one or two servings of a special dish unless it is unusually good; and then they serve it only rarely. After all it is customer demand which controls production and as the customer becomes more cautious in purchasing food the packers, producers and distributors of frozen food will need to have more efficient production lines and concentrate more effectively on items the customer will be likely to buy. This change is now being effected in the frozen food industry. Within the next few months and years the number, variety and cost of frozen foods will become more nearly standardized. So also will the quality.

Unfortunately, during the past two to three years the frozen food industry has attracted many amateurs with more interest in immediate profit than in maintaining the quality which assures continued acceptance. Many believed that here was a fertile field for profitable adventure, and adventure they did. The boom days of the California gold rush hardly brought forth more pioneers.

Many of these adventurers, who previously had considered food as merely something you ate three times a day but aside from that had given little, if any, thought or study to it, suddenly remembered Aunt Kate's recipe for cherry tartlets or Mother's clam chowder, made a batch, rented or borrowed freezing space, thawed it the following day and said, "My how good!" In two weeks the product had been made in larger kettles, a makeshift package had been found and its cover hastily printed and the product was launched amidst a hundred others in a few frozen food "coffins" in local stores. Depending upon the prowess and aggressiveness of the packer rather than upon the quality of the product, the item had a variable reception here and there for the first few weeks.

Meat products, such as stews, Creole dishes, hash, seafood Newburgs and creamed dishes, sold fairly well, at least at first, when meat supplies were high in price and often virtually unobtainable.

People who prepare food in institutional quantities are much more "cost per serving" conscious than the average housewife will ever be. But today when fresh porterhouse steaks can be obtained at around $1 for two generous servings, the majority of buyers will think twice before buying a package of frozen beef stew at 97 cents for three servings. Admittedly, the cost of the vegetables to be served with the steak must be considered, but those in the frozen stew—onions, potatoes, peas—are not luxury items and few would prefer stew to steak when the difference in cost is not too great.

Now that we have drawn attention to the weaknesses of the frozen food industry, what are the advantages? What are the future prospects once the industry is well stabilized?

Public Is More Critical

The frozen food industry, like many another new enterprise, has made mistakes. No individual can be blamed inasmuch as our system of free enterprise permits both the experienced and the inexperienced producer to pack frozen shrimp à la Creole or frozen peas and clamor for his share of the market. But Americans tend to be increasingly critical of the quality of foods and more willing to pay for quality food than we sometimes realize. They are not likely to buy a frozen product a second time if they do not like the first one they purchase. Sometimes the reason for disliking the product is due to faulty directions for preparing the food rather than to poor ingredients; sometimes the mixture is not suited to freezing. But whatever the cause, the undesirable products are soon spotted by their sales curve and their production is discontinued.

Already, as we said earlier, the industry is stabilizing itself. As might be expected, many larger packers with proper resources for research, storage studies, plant sanitation and product development who entered the field more cautiously and grad-

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Chop Suey **Salads** **Soups** **Fried Onions**
Creamed Onions **Steaks Smothered in Onions** **Stews**

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ually, introducing one or two quality items at a time, are continuing successfully because of the enduring and standardized quality of their products. This is also true of several small packers producing superior products who are equally aware of quality and avail themselves of every opportunity to maintain or improve the high standard of their product.

Because of the known variability in frozen foods and because the leading department stores in the United States and Canada were interested in merchandising frozen foods of a quality they could rely upon, the Frozen Food Foundation was established two years ago to promote quality in the freezing industry and to help the sustaining department stores in separating, as it were, the wolves from the sheep.

Tentative Grades Established

The task has not been easy. In the first place, we do not have rigid standards by which to judge quality in food with the precision that ore is analyzed or electrical equipment is inspected. The U. S. Department of Agriculture, however, has established tentative grades for a number of frozen fruits and vegetables. As in the canning industry, the acceptance of the grading system is voluntary and not too wide.

The vitamin C content of a product has proved an excellent index of quality because a marked loss of vitamin C means that something went wrong along the production line. The precooked and prepared items, on the other hand, are more difficult to check than are the fruits and vegetables. But on the whole considerable headway has been made and it is encouraging to note the increased interest in quality by the packers themselves. They can and will give the public quality products if and when the public demands them.

Frozen foods compete with fresh rather than canned foods in both price and quality. Frozen foods have the convenience factor which endears them to many housewives and dietitians even when the price is higher per serving than it is for the fresh. It is doubtful whether frozen foods, in the near future, can or will compete with canned items on the basis of price. The cost of refrigerated shipment and storage of frozen foods, of course, must be absorbed in the final price. As refrigeration costs decrease, the cost to the consumer may be reduced slightly. Then, too, as prices become more competitive, more efficient production and lower markups will bring the price of frozen foods more in line with that of other processed foods.

What frozen foods will be in plentiful supply during the next few years? Demand has already indicated that frozen fruits and vegetables are here to stay. Meats, however, are still uncertain items. Labor-management disputes affect the trend here because local butchers who now cut up carcasses shipped in from Chicago, Omaha or Kansas City do not take kindly to meats prepackaged and frozen at the source. Distribution costs are also much higher on frozen cuts than they are on chilled carcasses. Frozen fish and poultry are on much surer ground. They compete favorably with the fresh varieties and will be more widely available than at present.

The ready prepared and precooked frozen items are more in the luxury class. As long as our national income remains high we will buy them. The variety available will doubtless be less than at present but a goodly number of buyers will like to have several of these specialties on hand for emergencies and special occasions.

We have discussed frozen foods chiefly from the point of view of their use in the home. The institutional use of these foods, however, will parallel the home use quite closely. Frozen fruits, vegetables, eggs, fish and poultry, as a matter of fact, were accepted for institutional use more readily than they were for home use. Their continued use is assured so long as quality is maintained and the price is reasonable.

The ready prepared frozen foods, on the other hand, have never been aimed at the institutional market. It is doubtful if they will be to any extent.

Are there any new methods for handling frozen foods? The increased availability of small home freezers, large freezers and walk-in freezers makes it possible to keep a larger selection of frozen foods on hand. Suitable methods of defrosting large quantities quickly has been one problem. Electronic defrosting may be the answer. At present such equipment is expensive and of limited availability but within the near future its purchase should be within the budget limitations of most institutions. As yet this equipment is not practical for the home.

Storage life of all frozen foods is dependent upon the temperature. At 0° F. or below, fruits, vegetables, most meats, poultry, eggs and fish can be kept several months. The giblets in poultry should be wrapped separately because experiments have shown that if they are returned to the cavity of the cleaned bird, the storage life is shortened appreciably. Pork has a shorter storage life as it loses flavor and rancidity develops more rapidly in the fat. Prepared items, too, have a shorter storage life. Yeast products can be stored only a few weeks before the yeast becomes less viable and the dough does not rise so well. Baked goods can be held longer.

On removal from storage, frozen foods when defrosted should be used immediately because they are more perishable than are fresh foods.

Should Be Partially Defrosted

The cooking of frozen vegetables, meats, poultry and fish may be started with the food still in the frozen state or when partially defrosted. Chops, steaks and fillets for broiling or frying yield a more satisfactory product, however, if they are at least partially defrosted. Roasts take from one half to twice as long to cook if the process begins while the meat is still frozen. Frozen vegetables, because they have been partially cooked during blanching, have a shorter cooking period than do fresh vegetables. The use of pressure or steam kettles hastens the process of defrosting and cooking. Braising also speeds up the cooking for frozen chops and steaks. Frozen fillets need to be baked for only slightly longer periods than those required for fresh fillets.

Unquestionably, frozen foods are convenience foods. Their production serves to utilize seasonal labor, their use eliminates much spoilage and waste and they have excellent color and flavor. Inasmuch as these foods are available at all seasons they serve to stimulate sluggish winter appetites and provide the needed vitamins and minerals when fresh produce is expensive and scarce. They have proved their convenience, they are proving their quality and they will prove their economy.

More Menu Suggestions

Concluding the group of menus set forth by Doris Ann Boyle, assistant chief of the dietetic division of the Veterans Administration, in her article, "Let's Plan Menus," which appeared in the August issue.

Onion and potato soup
Stewed chicken with mushrooms en casserole
Watercress *Biscuit*
Small whole carrots
Molded fruit salad
Peppermint ice cream with fudge sauce

Fresh pineapple cup with chopped mint
Ham and veal pie with savory potato topping
Grilled tomato
Stuffed celery *Ripe olives*
Strawberry sundae

Consommé royal
Barbecued short ribs
Boiled potatoes
Braised carrots
Raw vegetable salad with sour cream dressing
Banana whipped cream pie

Mushroom bisque
Calves' liver
Whipped potatoes
Sautéed onions
Cabbage slaw
Peach pie with whipped cream

Baked halibut with cheese sauce
Hashed brown potatoes
Stewed tomatoes
Tomato and avocado salad
Rhubarb custard pie

Appetizer salad of avocado with diced celery *lime dressing*
Braised smoked tongue with raisin sauce
Parslied new potatoes
Broccoli, club style
Peaches in wine flavored jelly

Vegetable juice cocktail
Stuffed veal with olive sauce
Baked potatoes
Fresh spinach loaf with grated cheese
Old fashioned fruit salad
Layer cake with rum flavored filling and chocolate icing

Yankee pot roast with vegetables
Pan-browned potatoes
New beets with greens
Waldorf salad
Cheese cake with guava jelly

Mulligatawny soup
Baked meat loaf with vegetable gravy
Browned potatoes
Parslied new carrots
Head lettuce with French dressing
Sweet cherry pie with rum-flavored glacé

Grapefruit cup with strawberry rhubarb
Poached salmon with horseradish and whipped cream
Boiled new potatoes
Buttered new peas
Green cabbage slaw
Orange-date cake

Avocado with orange sections in cranberry juice
Fried chicken with cream gravy
Home-made noodles
Buttered green beans
Endive, watercress and lettuce salad
Caramel pie with whipped cream

Watercress and chive soup
Lamb chop with rasher of bacon
New potatoes and peas in cream
Orange-Waldorf salad
Coffee Bavarian cream with pecans

Fresh fruit with mint sherbet
Baked fillet of haddock with herb sauce
Hashed brown potatoes
Buttered broccoli
Relish tray
Old fashioned strawberry shortcake

Golden crusted perch with lemon
Potatoes au gratin
Medley of spring vegetables
Molded fruit salad
Assorted sherbet
Raspberries, lime and pineapple

Roast fresh ham *Gravy*
Whipped potatoes
Savoy cabbage
Mixed green salad with French dressing
Rhubarb Betty

Roast tenderloin with mushrooms
Potatoes paprika
Parslied cauliflower
Spring salad
Raspberry Bavarian cream

Fresh fruit cup with strawberry garnish
Individual chicken pie with biscuit topping
Fresh asparagus with vinaigrette sauce
Endive and watercress salad with French dressing
Fudge cake with fudge icing

Split pea soup
Pork chop baked with celery and onions
Baked sweet potatoes
Fresh applesauce
Cottage cheese with chives
Grapefruit sections in crême de menthe flavoring

FOOD FOR THOUGHT

One Book Takes a Bow, The Other— "How to Cook for Profit" by Madeline Gray and Vass de lo Padua ($5), purports to be "a complete guide to food in quantity from order pad to diner's table." The junior author, according to the publisher, is a "renowned food and restaurant efficiency expert," has "chefed all over the world." Miss Gray combines skill in cooking with ability to write concisely and to the point.

While written primarily for the restaurant manager, the book is, of course, largely applicable to any large or small food service. For instance, the author's 10 "golden rules" to observe if one is to cook for profit apply with equal force in the hospital kitchen. The list of essential tools for an average place serving from 150 to 200 persons per meal, their descriptions and their care, and the appended list of recommended but "not absolutely essential" equipment, too, will serve the hospital's needs as well as the restaurant's.

While few hospitals are operated for profit, the principles underlying the operation of the financially successful restaurant, if applied to the hospital cuisine, would lift the blight that lies so heavily on many hospital menus.

The authors waste no time in chitchat. Kitchen routines, quick methods of figuring portions on meats and vegetables, pricing for profit and the mysteries of the mirepoix are covered. Then follow excellent sections on soups,

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boiled, broiled, fried, sautéed, braised, stewed and potted dishes.

Under soups and other recipes the numbered step procedure is used and other details are given, such as "how to keep hot," amounts for table d'hôte and á la carte portions, how to serve and if foods are unsold what to do about it. Throughout the book are helpful sketches, such as that describing the breading of fried foods, carving meats and poultry and making mayonnaise.

This book is replete with helpful suggestions in the interest of economy and better food.

About the Other

Recent years have seen a succession of tiresome "cookbooks" supercharged with the author's rather dull personal experiences and views or, worse, his labored humor. "Maura Laverty's Cookbook," with a section on diet by Sybil Le Brocquy ($3), is another in the series. For those interested in "little chubby beets hollowed out and marinated in French dressing," then filled with peas liberally coated with mayonnaise, with other little beets submerged in chopped apple and celery or such dishes as cornstarch flummery and so on, the book may be of interest. The contribution on diet, to this reviewer, is equally profitless. Liver and milk are listed among the chief sources of vitamin C; leafy vegetables for vitamin D. Even here the cute style persists: "Your brain is more than three quarters water. If that worries you, remember that the jelly fish is 95 per cent water, poor fish!"

Hospitals Will Benefit by This

While written, as its title implies, specifically for restaurants and with a view to its use as a text in courses in hotel and restaurant administration, much of the information contained in the manual, "Establishing and Operating a Restaurant," by Mary DeGarmo Bryan, Alberta M. Macfarlane and E. R. Hawkins under the direction of the U. S. Department of Commerce, will apply to hospital food services. Chapters of special interest in this connection include: furnishings and equipment; personnel; menu planning; food purchasing; modern methods in restaurant cooking (including quick-frozen foods and glossary of cookery terms); food-cost records; timetables for cooking, and purchasing guides. The manual can be obtained for 45 cents on application to the Superintendent of Documents, Washington 25, D. C.

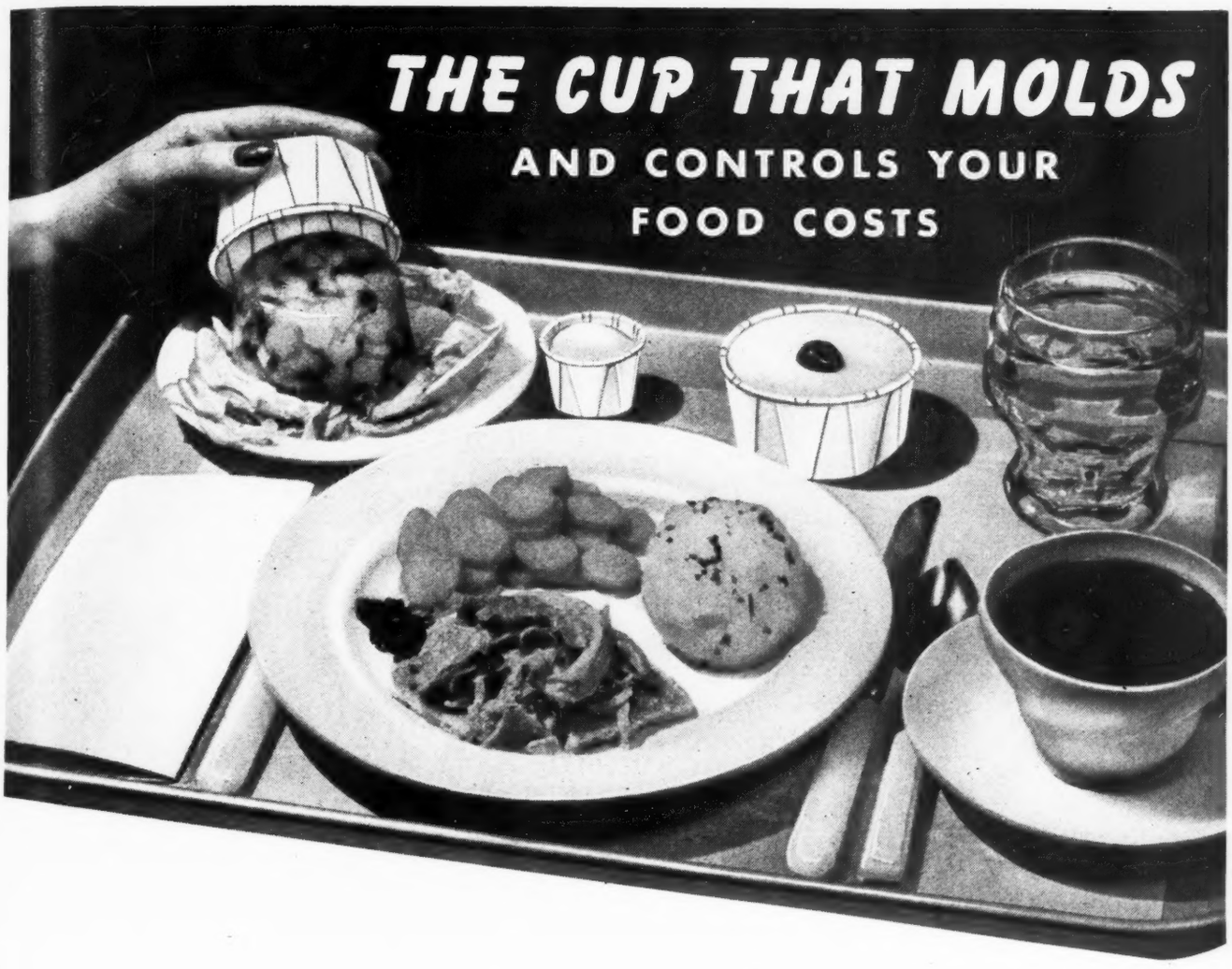
Herb Bulletin

In recent years the growing and use of savory herbs in cooking has had a revival. Many home gardeners today take special pride in their herb bed and modern cooks use garden seasonings to flavor both plain and fancy dishes.

For both gardeners and cooks the U. S. Department of Agriculture has published a new bulletin — "Savory Herbs, Culture and Use" (F.B. 1977). Single copies may be had free on request from the Office of Information, U. S. Department of Agriculture, Washington, D. C.

How to Fry Chicken

Fried chicken can be good or bad, according to the way it is prepared. The right way to select, prepare and cook this dish is the subject of a bulletin prepared by Kathryn B. Niles, home economics director, Poultry and Egg National Board, Chicago, for the National Restaurant Association. "First," says Miss Niles, "it is important that a young bird be used; second, that the chicken be cooked in fat at a moderately low temperature and, last, that the chicken be cooked long enough to reach the fork-tender stage. Preferable is a chicken with flexible-tipped keel bone, tender-fleshed and thin, waxy skin. It should not be more than five months old and weight should be from 1½ to 3½ pounds.



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Menus for October 1947

Edith L. Strock
Frederick City Hospital
Frederick, Md.

1
Stewed Prunes
Broiled Bacon
•
Mirute Steak
Paprika Potatoes
String Beans
Carrot, Celery and
Pineapple Salad
Vanilla Pudding
•
Cold Cuts
Potato Salad
Tomato Wedges
Royal Anne Cherries
Chocolate Chip Cookies

2
Honey Dew Melon
Scrambled Eggs
•
Roast Chicken
Dressing and Gravy
Mashed Potatoes
Creamed Cauliflower
Celery Hearts and Olives
Fruit Gelatin With
Whipped Cream
•
Chicken and Rice Soup
Veal Croquettes, Catchup
Lima Beans
Peach and Date Salad
Pound Cake

3
Half Grapefruit
Broiled Ham
•
Broiled Haddock Fillet,
Lemon Butter Sauce
Parsley Potatoes
Stewed Tomatoes
Mixed Green Salad
Bread Pudding
•
Eggs à la Golden Rod
on Toast
Baked Potatoes
Asparagus Salad
Canned Blue Plums

4
Sliced Bananas
Soft Cooked Eggs
•
Roast Lamb With Gravy
Franconia Potatoes
Buttered Peas
Mint Jelly, Radishes
Pineapple Upside-Down
Cake
•
Beef Stew With
Vegetables
Coleslaw
Hot Biscuits and Jelly
Canned Apricots

5
Orange Slices
Broiled Bacon
•
Fried Chicken With Gravy
Mashed Potatoes
String Beans
Fresh Fruit Salad
Chocolate Ice Cream
•
Cream of Tomato Soup
Saltines
Cold Plate: Sliced Cheese,
Potato Chips, Golden-Glow
Salad
Caramel Layer Cake

6
Kadota Figs
Shirred Eggs
•
Breaded Veal Cutlets,
Mushroom Gravy
Baked Potatoes
Buttered Broccoli
Lettuce Hearts, French
Dressing
Cherry Cobbler
•
Creamed Chicken in
Timbales
Julienne Carrots
Tomato Salad -
Baked Apples

7
Stewed Peaches
Breakfast Sausage
•
Roast Beef With Gravy
Parsley Potatoes
Mashed Rutabagas
Radish Roses and
Celery Curls
Prune Whip
•
Broiled Calf's Liver
Bacon Strips
Escalloped Potatoes
Pear Salad
Cup Cakes

8
Half Grapefruit
Soft Cooked Eggs
•
Chicken Fricassee
Mashed Potatoes
Mexican Corn Sauté
Spiced Crabapples
Gingerbread With
Whipped Cream
•
Baked Macaroni and
Cheese
Buttered Asparagus
Mixed Green Salad
Canned Apricots
Vanilla Cookies

9
Tangerines
French Toast, Sirup
•
Meat Loaf With Gravy
Paprika Potatoes
Harvard Beets
Fresh Fruit Salad
Vanilla Ice Cream
•
Lamb Chops
Fluffy Rice
Stuffed Tomato Salad
Lemon Snow Pudding
With Custard Sauce

10
Compote of Stewed Fruits
Poached Egg on Toast
•
Broiled Salmon Steaks,
Egg Sauce
Parsley Potatoes
Peas and Carrots
Lettuce Hearts, Russian
Dressing
Cottage Pudding With
Orange Sauce
•
Split Pea Soup
Bacon, Lettuce and
Tomato on Finger Roll
Soft Custard With
Frozen Strawberries

11
Orange Slices
Broiled Pork Fry
•
Broiled Steak
Creamed Potatoes
Succotash
Apple and Date Salad
Creamy Rice Pudding
•
Baked Corned Beef Hash
With Poached Egg
Molded Vegetable Salad
Charlotte Russe

12
Tokay Grapes
Scrambled Eggs
•
Baked Ham
Candied Yams
Buttered Spinach
Grapefruit and Avocado
Salad
Pineapple Sherbet
•
Chicken-Noodle Soup
Cold Plate: Tuna Salad,
Bread and Butter Sand-
wiches, Spiced Peach
Brownies

13
Sliced Bananas
Broiled Bacon
•
Lamb Stew
Hot Biscuits
Orange and Plum Salad
Butterscotch Pudding
•
Broiled Steak
Delmonico Potatoes
Tossed Green Salad
Concord Grapes

14
Stewed Apples
Soft Cooked Eggs
•
Roast Veal With Gravy
Mashed Potatoes
Buttered Cauliflower
Assorted Relishes
Apricot Cobbler
•
Ham Croquettes With
Mushroom Sauce
Baked Potatoes
Fresh Fruit Salad
Spice Cup Cakes

15
Orange Halves
Breakfast Sausage
•
Short Ribs of Beef
Steamed Noodles With
Gravy
String Beans
Lettuce Hearts, French
Dressing
Strawberry Ice Cream
•
Creamed Eggs on Toast
Parsley Potatoes
Tomato Aspic Salad
Pineapple Shortcake With
Whipped Cream

16
Half Grapefruit
Scrambled Eggs
•
Roast Beef With Gravy
Parsley Potatoes
Buttered Carrots
Pear Salad
Chocolate Pudding With
Whipped Cream
•
Creamed Chipped Beef
on Toast
Baked Potatoes
Asparagus Salad
Bing Cherries

17
Stewed Prunes
Broiled Bacon
•
Broiled Halibut Steaks,
Lemon Garnish
Mashed Potatoes
Spinach
Lettuce Hearts, Russian
Dressing
Lemon Cake Pudding
•
Broiled Chicken
Fluffy Rice
Cooked Vegetable Salad
Peach Tapioca

18
Tomato Juice
Shirred Eggs
•
Beef Patties
Baked Noodles
Harvard Beets
Grapefruit Salad
Gingerbread With Custard
Sauce
•
Navy Bean Soup
Saltines
Deviled Egg Salad,
Pickle Garnish
Baked Apples

19
Kadota Figs
Broiled Ham
•
Lamb Chops
Mashed Potatoes
Frozen Peas
Pineapple Salad
Vanilla Ice Cream, Hot
Fudge Sauce
•
Club Sandwich
Potato Chips
Olive and Pickle Garnish
Fruit Compote
Macaroons

20
Stewed Prunes
Poached Eggs on Toast
•
Salisbury Steak, Spanish
Sauce
Franconia Potatoes
Lima Beans
Lettuce Hearts, French
Dressing
Fruit Gelatin With
Whipped Cream
•
Broiled Ham
Potatoes au Gratin
Carrot and Celery Salad
Date Delight

21
Half Grapefruit
Scrambled Eggs
•
Broiled Chicken
Mashed Potatoes With
Gravy
Broccoli With Lemon
Butter Sauce
Stuffed Celery
Cottage Pudding, Orange
Sauce
•
Creamed Sweetbreads and
Mushrooms on Toast
Baked Stuffed Potatoes
Tomato Salad
Prune Whip

22
Compote of Stewed Fruits
Soft Cooked Eggs
•
Swiss Steak
Parsley Potatoes
Buttered Beets
Peach Ice Cream
•
Vegetable Plate: Buttered
Asparagus, Julienne Car-
rots, Green Beans
Pear and Cottage Cheese
Salad
Frosted Spice Cake

23
Orange Slices
Broiled Bacon
•
Veal Chops
Creamed Potatoes
Kale
Assorted Relishes
Blancmange With Cherry
Sauce
•
Shepherd's Pie
Mixed Green Salad
Sliced Peaches
Cookies

24
Applesauce
Scrambled Eggs
•
Salmon Loaf With Egg
Sauce
Steamed Potatoes
Baked Tomatoes
Berry Cobbler
•
Vegetable Soup
Saltines
Grilled Cheese Sand-
wiches
Tomato and Pickle Garnish
Royal Anne Cherries

25
Sliced Bananas
Broiled Bacon
•
Roast Lamb With Gravy
Franconia Potatoes
Buttered Peas
Fresh Fruit Salad
Tapioca Cream
•
Chicken-Okra Soup
Spanish Rice
Spinach With Chopped
Egg
Perfection Salad
Chocolate Layer Cake

26
Half Grapefruit
Breakfast Sausage
•
Baked Chicken
Dressing and Gravy
Mashed Potatoes
Creamed Celery and
Carrots
Lettuce With French
Dressing
Peach Ice Cream
Cookies
•
Cream of Mushroom Soup
Chicken Salad
Potato Chips
Garnishes
Charlotte Russe

27
Tomato Juice
Soft Cooked Eggs
•
Meat Loaf With Gravy
Paprika Potatoes
Buttered Cauliflower
Celery Hearts and Radish
Roses
Bread Pudding
•
Lamb Chops
Broiled Pineapple Slice
Baked Potatoes
Asparagus Salad
Fruited Gelatin

28
Fresh Apples
Broiled Bacon
•
Roast Veal With Gravy
Mashed Potatoes
String Beans
Lettuce Hearts With
Russian Dressing
Boston Cream Pie
•
Chicken à la King
on Hot Biscuits
Chef's Salad
Fruit Cocktail
Cookies

29
Orange Halves
Scrambled Eggs
•
Beef Stew With
Vegetables
Coleslaw
Pineapple Upside-
Down Cake
•
Broiled Haddock Fillets
Parsley Potatoes
Tomato Salad
Chocolate Marshamallow
Pudding

30
Stewed Prunes
Poached Eggs
•
Baked Ham With
Raisin Sauce
Whipped Sweet Potatoes
Buttered Broccoli
Pear Salad
Vanilla Ice Cream
•
Italian Spaghetti
With Meat Balls
Lettuce With French
Dressing
Canned Whole Apricots

31 Baked Apples, Broiled Bacon • Fried Fillet of Sole, Tartare Sauce, Mashed Potatoes, Buttered Spinach, Carrot Strips and Black Olives, Pumpkin Pie • Broiled Steak, Escalloped Potatoes, Peach and Date Salad, Doughnuts and Cider

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Ask Your Heinz Man About

HEINZ 57 SOUPS

PLANT OPERATION & MAINTENANCE

Long Life to Your Elevators

ERNEST W. FAIR
Bristow, Okla.

EVERY hospital administrator knows that he cannot check his elevators too often, for lack of maintenance here can so easily lead to tragedy that it is unthinkable.

The average periodic building check on elevators is too often confined purely to safety factors, and the electrical wiring and operating devices are overlooked. The fact that faults may arise therein and not result in possible loss of life tends to make us all lax at this point.

However, these are the very elements that contribute to elevator breakdown, and while the danger may not be so great the elements of inconvenience, disruption of service and increased costs incident to this condition are all present. There is also the matter of obtaining the maximum useful life from this part of the hospital equipment.

Check These Points

In the paragraphs to follow are a number of ideas culled from hospital elevator experience, engineers' recommendations and other sources, which can well be added to every hospital manager's list of points that should be checked at regular intervals in order that elevators will be properly maintained.

1. No part of any electric circuit having a voltage in excess of 750 volts should be used on any car control system. Circuits of higher voltage may be used in machine rooms or penthouses for the operation of motors and brakes, provided that all controls and signal wiring are thoroughly insulated from such power circuits.

2. Maximum recommended voltage in the operating devices of automatic elevators that have such devices in the car and at the landings should be 300 volts to ground.

3. The maximum voltage permitted on the push buttons of elevator signaling circuits should be 300 volts to ground.

4. Armored cable, rigid metal conduit, flexible metal conduit and electrical metallic tubing are the only forms of wiring advisable between riser and limit switches, interlocks, push buttons and similar devices.

5. Rigid metal conduit and electrical metallic tubing may be used for other elevator wiring purposes.

6. Conductors and traveling cables, when they are attached to a car, should be run in rigid metal conduit, electrical metallic tubing or wireways.

7. No conduit or cable except those used to furnish or control power, light, heat or signals for the elevator or hoistways should have an opening, terminal, outlet or junction within the hoistway, but they should be continuous between outlets or terminals situated entirely outside the hoistway.

8. When feeders are installed in an elevator shaft, a pull box or a cable-support box may be installed in the shaft; no taps should be made in such a box.

9. Supports for conduit and armored cable in the hoistway should always be securely fastened to the guide rail or hoistway construction.

10. Conductors or groups of conductors having flame retardant outer covers should not be used as connections for the operating circuits of elevator controllers unless such outer coverings are also moisture resistant. Asbestos and similar coverings may cause the controller to function incorrectly.

11. Traveling cables used for circuits other than signal circuits should either be a composite assembly of copper and steel wires or have one or more supporting fillers of cotton or hemp rope or cotton covered or rubber covered steel wire.

12. Conductors of car lighting circuits and signal systems, when they are not an integral part of the elevator wiring system, should be separated and run in separate raceways and traveling cables.

13. Wherever the traveling cables come in contact with projections or corners of the building construction in the hoistway, such as I-beams and ledges, such irregular surfaces should be made smooth by covering with heavy-gauge sheet metal or other similar material.

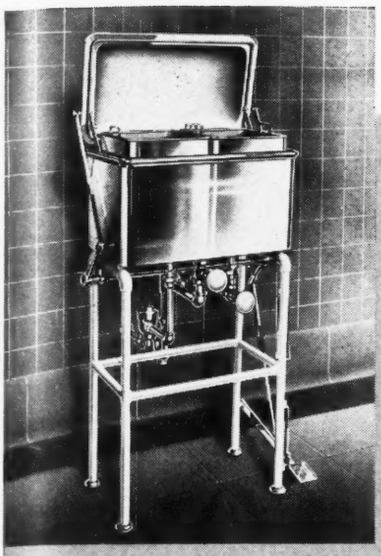
14. There should always be a means for disconnecting all conductors of the motor branch circuits. This should be located within sight of the motor unless special permission is given to locate it elsewhere.

15. When two or more elevator motors are located in one machine room, a single switch or circuit breaker can be used to disconnect all of the motors.

16. Every elevator operated by a polyphase alternating current motor should be provided with a device which will prevent starting of the motor if the phase rotation is in the wrong direction, or if there is a failure in any phase.

17. Limit switches should always be checked for both the upper and lower limits of travel for all elevators, and on every maintenance check it should be made certain that they are operating correctly.

18. The elevator machine and controller should be installed in a room set aside for that purpose and should be thoroughly enclosed; the guards around these units should be



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SCANLAN-MORRIS Electrically Heated Instrument Sterilizer. Foot pedal operates cover and tray simultaneously. The full-sized deep tray is roller-equipped for easy handling. Built of Monel to withstand constant hard service.

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...in these Scanlan-Morris Sterilizers

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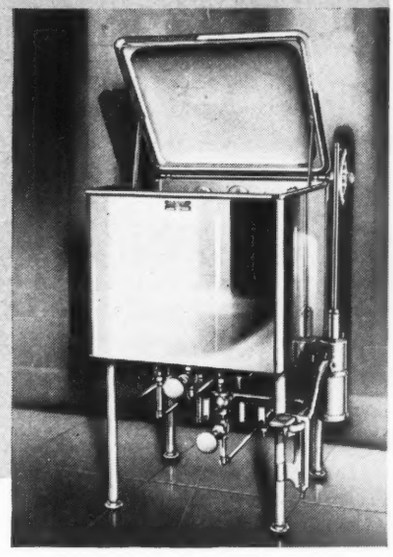

Yes—*solid advantages*. You get them only from a *solid* metal.

A metal, for example, like Monel*.

This popular Nickel Alloy has no surface coating to chip, peel or wear away.

It's rustproof . . . strong . . . tough . . . hard . . . *all the way through!*

Those are some of the reasons why THE OHIO CHEMICAL & MFG. CO., Madison, Wis., now standardizes on Monel for steam heated, gas heated, and electrically heated boiling type sterilizers.

Of course, there are other reasons, too. And the chances are you know them if you've had experience with Monel anywhere in the hospital.

In operating room, clinic and laboratory . . . in hydrotherapy department, kitchen, cafeteria and laundry, this silvery Nickel Alloy does many jobs . . . and does them well.

For Monel resists corrosion and staining. It stands up against heat, steam and moisture, against acids, alkalies and a wide range of hospital solutions. Hard and constant use cannot dim its attractive, satiny lustre.

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Monel* **STANDARD METAL OF THE MODERN HOSPITAL**

EMBLEM OF SERVICE INCO TRADE MARK

*Reg. U.S. Pat. Off.

THE INTERNATIONAL NICKEL COMPANY, INC., 67 WALL STREET, NEW YORK 5, N. Y.

checked regularly and no unit should be left unguarded.

19. All live parts of electrical apparatus in or on elevator cars or in elevator hoistways should be enclosed to protect against accidental contact.

20. All frames of cars and controllers should be grounded and it is always wise to check these grounds regularly.

21. Conduit or armored cable attached to elevator cars should be bonded to the grounded metal parts of the car with which they come in contact.

HOUSEKEEPING

Conducted by Alta M. La Belle and Jane Barton

Teach Employes to Work Safely

B. B. LOVELL Jr.

Chief Engineer
Hartford Hospital, Hartford, Conn.

SAFETY in the hospital covers a broad field and volumes could be written about it. This discussion will be limited to the problems of fire and accident prevention, particularly as these affect the housekeeping department. It must be understood, however, that no single department of a hospital can successfully wage a safety program without the continuous cooperation of the personnel of all other departments.

Let us first consider fire prevention. It is absolutely essential that some individual in the hospital organization be given the responsibility and the authority to organize and conduct a fire prevention program. In the larger hospitals it is recommended that a full time trained fire marshal be employed, preferably a retired officer from the city fire department.

The smaller hospitals may assign a department head to assume this responsibility. He must conduct a training program whereby *all* employes are taught the fundamentals of fire prevention and are made aware of the fire hazards peculiar to hospitals. Every employe must be taught to use the several types of fire extinguishers commonly found in hospitals and to know which extinguishers may be safely used on electrical or grease fires.

I know of several occasions when nurses, using soda-acid extinguishers, have put out hospital fires. They reported that the practice they had received in the fire prevention program had made them familiar with the operation of the extinguishers; hence, there was no hesitation when the emergency arose.

The fire marshal must also organize and conduct fire drills for the safe evacuation of patients and employes from the building. He must arrange for the mobilization of manpower to move the patients and he must map out the preferred and secondary exit routes to be followed in case of emergency. These exit routes must be charted and posted on the walls of the nurses' station at each nursing unit.

The fire marshal is also responsible for making routine inspections of the hospital property and making a written report of his findings to the superintendent. He inspects for rubbish in out-of-the-way places, checks all fire alarms, extinguishers, hose, electrical wiring, exit facilities and sprinkler systems.

The housekeeping department must work with the fire marshal in seeing that the premises are clean inasmuch as "good housekeeping" is the first requisite of fire prevention. It is notable that a disorderly shop, storeroom or maid's closet frequently receives an unfavorable fire inspection report, yet when the same materials are neatly arranged in the same room, the report is favorable. This is an indication that neatness is essential to good fire prevention.

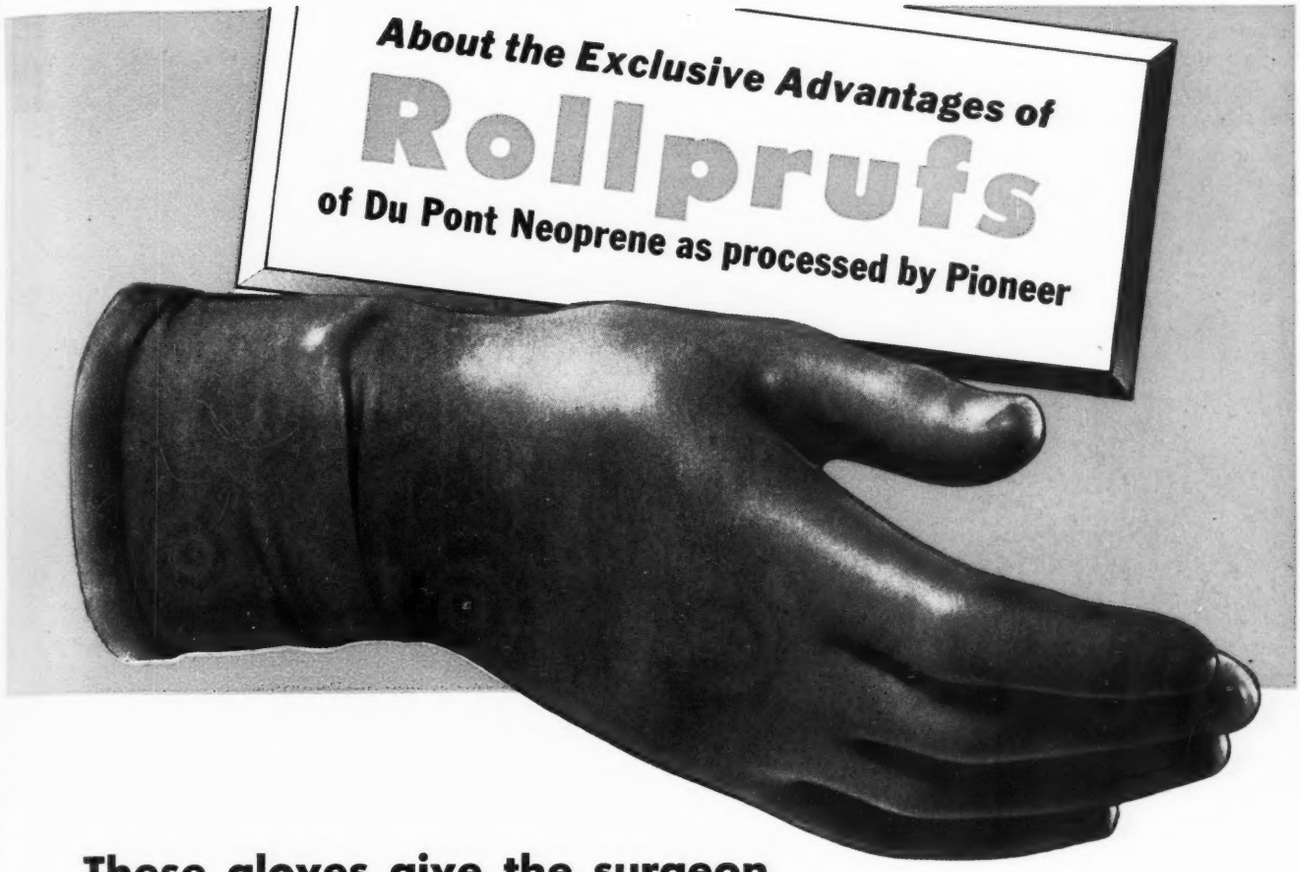
All waste paper containers should be made of metal, the larger ones being provided with metal covers, and paper collections should be frequent enough to prevent overflow. Paper and cloth should not be allowed to come in contact with uninsulated steam pipes because the steam temperature (212°-230° F.) is usually sufficient to ignite these materials if the slightest amount of oil or grease is present. Oily rags should be kept in underwriters' approved oily waste cans.

It is essential that the bulk storage of volatile liquids, such as alcohol, ether, benzine, toluol and gasoline, be in an approved storage vault constructed according to recommendations of the National Fire Prevention Association and equipped with ventilating equipment and a CO_2 fire extinguishing system. The transferring of volatile liquids from one container to another should always be done in this room and all such liquids removed from the room should be carried in approved safety cans, never in glass bottles.

Small bottles, not exceeding 4 ounces in capacity, may be filled from the safety cans for dispensing as necessary. By limiting the flammable contents of a glass bottle to 4 ounces we reduce the hazard of a large flash fire if the bottle were accidentally spilled or broken. Empty one pound ether cans make acceptable containers for benzine when painted bright red and prominently marked with the name of the contents. The metal container is preferable to the glass bottle since it is not likely to break from being dropped or from the heat of a surrounding fire.

A paint shop should never be located in a building used to house patients or personnel and when hospital

Presented at the New England Hospital Assembly meeting, March 1947.



These gloves give the surgeon the skill-aiding comfort of extra finger freedom

THERE'S something unusual about Rollpruf Surgical Gloves of neoprene which many surgeons have told us they find out a few minutes after they put on a pair. These soft textured gloves seem to relax on the hand so that the fingers enjoy a new freedom that is not only an added comfort but a marked aid to highest surgical skill.

If true, it's an advantage every surgeon will want to investigate for himself.

And when you try tissue-sheer neoprene Rollprufs, you find also that they give you extra finger-tip sensitivity, reduced cramping of your hands in long wearing, snug fit without wrinkles and because of the flat-banded cuffs, no roll-down to annoy during operations. And they're evidently free of the rubber allergen that causes dermatitis.

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Neoprene must not be confused with synthetics used in tires. Pioneer's 9 years of experience with it prove its extraordinary advantages in a surgical glove. Besides, neoprene stands contact with oils, petrolatum or acids that damage rubber.

PIONEER *Surgical Gloves*

The Result of Over 25 Years of Quality Glove Making

rooms are being painted care should be taken to remove all materials at night inasmuch as spontaneous combustion in paint or turpentine soaked rags is a frequent cause of fire.

Rooms in which 75 or more persons may gather are usually considered places of public assembly and in these spaces the draperies, curtains, stage props, upholstery and decorations should be permanently flameproofed. Christmas trees must never be allowed in hospital buildings.

Upholstery Shop Hazardous

The upholstery shop is usually considered a hazardous area because of the concentration of the materials of that trade. All horsehair, cotton padding, burlap and such material should be stored in metal lined bins, preferably with a sprinkler head in each bin. The smoke resulting from burning horsehair is particularly dense and greasy and can do great damage to walls and furniture in rooms at a considerable distance from the fire.

It would be well when purchasing electrical apparatus, such as vacuum cleaners and floor polishers, that underwriters' labeled equipment be specified. "The label constitutes a report by Underwriters Laboratories, Inc., that the device (or material) to which it is attached has been produced under the factory inspection service of the laboratories and that it complies with the requirements of the laboratories' standards for such devices."

The engineering department should be responsible for the maintenance of fire extinguishers, sprinkler systems, fire alarms, fire hose and electrical systems, but the personnel of the housekeeping department should be prompt in calling the attention of the engineering department to any defects noted in the aforementioned apparatus. This does not relieve the engineering department of the responsibility of making routine inspections of this equipment but does help in making prompt repairs.

Poor electric wiring is a frequent cause of fire, especially in old buildings where exposed wiring may still be in use. It is essential that proper fusing be installed and under no circumstances should fuses over 15 ampere capacity be used except in so-called "heavy duty" circuits especially wired for this load. Cords for lamps should be frequently inspected and if the insulation is worn the cord should be replaced with underwriters' labeled cord. The practice of running extension cords under rugs should be discouraged because of the hazard of tripping and also the possibility of the cord's becoming worn and bare.

Flatirons are a problem because they draw a heavy electric load and are also capable of starting a fire from the heat of the iron itself. It is recommended that in nurses' residences and wherever ironing is necessary, special rooms be provided for this purpose. Ironing boards should be provided with sheet asbestos under the padding and heavy duty electrical circuits should be installed for the irons. These circuits are energized through a wall switch which lights a pilot light over the room door in the hall, thus warning the watchman if an iron is left plugged in. It is also recommended that the hospital provide the flatiron and that it be of the thermostatic control type and be permanently fastened to the electric outlet.

Let us now briefly consider accident prevention. It is the duty of the hospital administration to prevent, as far as is possible, any accidents to patient, public and personnel. Here, again, an educational program is essential. It is suggested that monthly meetings of all department heads be held at which a representative of the casualty insurance company gives a brief talk on accident prevention and reviews any accidents that occurred to personnel during the preceding month. A series of safety posters can be made, illustrating how to avoid the common accidents.

The housekeeping department has a major rôle in this accident prevention program. Housekeeping employes must be taught how to perform their work safely. They must be shown the hazards to which they and the public are exposed while doing certain routine jobs. Floors must be kept in good condition and "nonskid" waxes should be used where wax finishes are desirable. It should be noted that a conductive rubber or linoleum floor in an operating room should never be waxed except with a special product that is approved for conductivity because ordinary waxes will interfere with the electrical conductivity of the floor. When floors are being cleaned and waxed only small areas should be done at a time and the work space should be marked off with wooden horses connected by ropes; these protective devices should be left in place until the floor has had its final buffing. The horses should be brightly painted and suitably marked to attract attention and indicate the danger.

The electric cord providing current for the floor machine frequently must lie across the corridor or some other traveled portion and it has been found advantageous to provide triangular metal signs, marked "Watch Your Step," through which the cord can be passed. This simple device obviates the danger of someone's tripping over the cord. Any water or other liquid spilled on the floor should be immediately wiped up to prevent falls.

It is considered good management to provide safe tools for workmen, such as approved safety step ladders, metal scaffolds for reaching the walls and ceilings of large rooms, safety harness or window scaffolds for use when washing windows and underwriters' approved electrical equipment.

Don't Obstruct Passageways

Corridors and passageways should never be obstructed with beds, wheelchairs and stretchers because these may prevent rapid exit in case of emergency. All exit doors should swing out in the direction of travel and must never be locked to prevent exit. Fire escapes must not be obstructed, and care should be taken to see that they are clear of snow and ice at all times.

A vast amount of assistance is available to anyone wishing to establish a safety program in a hospital. The innumerable pamphlets available from the underwriters' laboratories and the National Fire Prevention Association may be obtained at insignificant expense. In fact, it would be well for all hospitals to become members of the National Fire Prevention Association so that they can benefit by the technical service and the many pamphlets of that organization. It should also be noted that fire and liability insurance companies have trained engineers who are at your service for the asking and, finally, the local fire department is always available for consultation regarding fire prevention and fire fighting programs.

NEWS DIGEST

Runaway Construction Costs Halt V.A. Hospital Building Program

By EVA ADAMS CROSS

WASHINGTON, D. C.—General Bradley's recent detailed statement concerning runaway construction costs as they affect the Veterans Administration hospital construction program will bring closer scrutiny of hospital building projects throughout the nation.

V.A. has an appropriation of $772,702,845 to cover its hospital construction program. The administrator declared all desirable but nonessential features of a substantial number of structures on the drawing boards must be modified or an additional $100,000,000 will be required.

Examination of the preliminary layouts for a number of hospitals under design has shown that they cannot be built at today's prices on the funds allotted them a year ago, said General Bradley. A hospital that cost 85 cents per cubic foot in 1945 would have cost $1.25 per cubic foot in 1946. At today's excessive prices, the same hospital would cost the taxpayer about $1.80 for the same cubic footage, he estimated.

V.A.'s administrator pointed out also that there is evidence that contractors are adding a 15 to 30 per cent "fear contingency cushion" to active construction bids because of the danger of further increases in construction costs and the possibility of material shortages. Even today we have no assurance, he warned, that labor and material costs will not continue to rise above existing market prices. It must be realized that even savings made in the modification of design can be wiped out by further increases in cost.

"We shall not save space at the expense of medical treatment and we shall not trim costs at the expense of medical care," declared General Bradley. Each new hospital will contain an adequate number of operating rooms, laboratories and adjunct facilities. In no instance will the modern and efficient characteristics of these hospitals be sacrificed for savings.

As far as possible, however, nonessential hospital space in structures under design must be reduced, said the administrator. This may mean elimination from some hospitals of such desirable features as adequate staff and office space, doctors' quarters, theaters and other facilities ordinarily associated with veterans' hospitals.

Though V.A. hospital construction will be delayed in numerous instances through this restudy and revision of plans, let no one think that this pause for space and cost conservation is putting the economics of hospital construction before the human needs of sick and wounded veterans, General Bradley contended.

For too many years insistence on the quantity of hospital beds has been permitted to obscure the quality of medicine that is practiced in those beds, he continued. By concentrating first upon its professional services, by linking its program to medical schools, by increasing its standard of medical care, the Veterans Administration in two years has provided the equivalent of more than 40,000 hospital beds.

Despite the need for restudy, the Veterans Administration will proceed on the eight hospitals already under partial or full construction contracts. Delay in construction of some 14 hospitals will amount to approximately thirty days. Six other hospitals will probably escape revision altogether. Another five will be unaffected by delays in the space and cost conservation plan. Modifications will be concentrated in 37 hospitals where preliminary plans suggest the need for space reduction.

Two Brooklyn Hospitals Merge; Now Maimonides

NEW YORK.—Beth Moses and Israel Zion hospitals of Brooklyn have announced their merger into a single institution to be known as Maimonides Hospital, Norman S. Goetz, president of the Federation of Jewish Philanthropies of New York, announced last month.

The two hospitals will continue to occupy present buildings and carry on existing functions, Mr. Goetz said. Ultimately, however, the merger plans for the combined hospital call for expansion of present Israel Zion facilities to provide care for acute patients and use of the existing Beth Moses Hospital for long term illnesses.

Dr. John B. Pastore, executive director of the Hospital Council of New York, said the merger was a first step toward realization of the council's master plan for providing adequate facilities for the care of chronic illness in the metropolitan area.

The unified hospital will have a single board of trustees and one medical staff.

N. Y. U. Has Regional Hospital Plan for Postgraduate Training

NEW YORK.—New York University College of Medicine, in cooperation with several rural and suburban hospitals in the metropolitan area, will undertake a regional hospital plan aimed at providing postgraduate training for physicians, Dr. Clarence E. de la Chapelle, associate dean, announced last month. The plan will begin to function at the start of the academic year, he said.

Participating hospitals are New Rochelle Hospital, New Rochelle, N. Y.; Flushing Hospital and Dispensary, Flushing, Queens; Monmouth Memorial Hospital, Long Branch, N. J.; Fitkin Memorial Hospital, Neptune, N. J.; St. Luke's Hospital, Newburgh, N. Y., and North Country Community Hospital, Glen Cove, L. I.

Under the new program, young attending physicians of the participating hospital staffs will have a year's study at the college of medicine after a full year of hospital work at the university's expense. Residence and maintenance expenses will be paid by the hospitals. During this period members of the college faculty will make monthly visits to the cooperating hospitals to organize and participate in conferences, seminars and other academic activities requested by the hospital staffs.

The plan is aimed at providing continuing educational interest for physicians for the first five years following graduation. "It is during these years," Dr. de la Chapelle said, "that the young physician acquires habits and methods of work which will determine his professional success or failure. It is important that the medical school assume responsibility for added training of the young doctor during these formative years."

Army Sets Deadline for Nurse Applicants

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NEWS DIGEST

Runaway Construction Costs Halt V.A. Hospital Building Program

By EVA ADAMS CROSS

WASHINGTON, D. C.—General Bradley's recent detailed statement concerning runaway construction costs as they affect the Veterans Administration hospital construction program will bring closer scrutiny of hospital building projects throughout the nation.

V.A. has an appropriation of $772,702,845 to cover its hospital construction program. The administrator declared all desirable but nonessential features of a substantial number of structures on the drawing boards must be modified or an additional $100,000,000 will be required.

Examination of the preliminary layouts for a number of hospitals under design has shown that they cannot be built at today's prices on the funds allotted them a year ago, said General Bradley. A hospital that cost 85 cents per cubic foot in 1945 would have cost $1.25 per cubic foot in 1946. At today's excessive prices, the same hospital would cost the taxpayer about $1.80 for the same cubic footage, he estimated.

V.A.'s administrator pointed out also that there is evidence that contractors are adding a 15 to 30 per cent "fear contingency cushion" to active construction bids because of the danger of further increases in construction costs and the possibility of material shortages. Even today we have no assurance, he warned, that labor and material costs will not continue to rise above existing market prices. It must be realized that even savings made in the modification of design can be wiped out by further increases in cost.

"We shall not save space at the expense of medical treatment and we shall not trim costs at the expense of medical care," declared General Bradley. Each new hospital will contain an adequate number of operating rooms, laboratories and adjunct facilities. In no instance will the modern and efficient characteristics of these hospitals be sacrificed for savings.

As far as possible, however, nonessential hospital space in structures under design must be reduced, said the administrator. This may mean elimination from some hospitals of such desirable features as adequate staff and office space, doctors' quarters, theaters and other facilities ordinarily associated with veterans' hospitals.

Though V.A. hospital construction will be delayed in numerous instances through this restudy and revision of plans, let no one think that this pause for space and cost conservation is putting the economics of hospital construction before the human needs of sick and wounded veterans, General Bradley contended.

For too many years insistence on the quantity of hospital beds has been permitted to obscure the quality of medicine that is practiced in those beds, he continued. By concentrating first upon its professional services, by linking its program to medical schools, by increasing its standard of medical care, the Veterans Administration in two years has provided the equivalent of more than 40,000 hospital beds.

Despite the need for restudy, the Veterans Administration will proceed on the eight hospitals already under partial or full construction contracts. Delay in construction of some 14 hospitals will amount to approximately thirty days. Six other hospitals will probably escape revision altogether. Another five will be unaffected by delays in the space and cost conservation plan. Modifications will be concentrated in 37 hospitals where preliminary plans suggest the need for space reduction.

Two Brooklyn Hospitals Merge; Now Maimonides

NEW YORK.—Beth Moses and Israel Zion hospitals of Brooklyn have announced their merger into a single institution to be known as Maimonides Hospital, Norman S. Goetz, president of the Federation of Jewish Philanthropies of New York, announced last month.

The two hospitals will continue to occupy present buildings and carry on existing functions, Mr. Goetz said. Ultimately, however, the merger plans for the combined hospital call for expansion of present Israel Zion facilities to provide care for acute patients and use of the existing Beth Moses Hospital for long term illnesses.

Dr. John B. Pastore, executive director of the Hospital Council of New York, said the merger was a first step toward realization of the council's master plan for providing adequate facilities for the care of chronic illness in the metropolitan area.

The unified hospital will have a single board of trustees and one medical staff.

N. Y. U. Has Regional Hospital Plan for Postgraduate Training

NEW YORK.—New York University College of Medicine, in cooperation with several rural and suburban hospitals in the metropolitan area, will undertake a regional hospital plan aimed at providing postgraduate training for physicians, Dr. Clarence E. de la Chapelle, associate dean, announced last month. The plan will begin to function at the start of the academic year, he said.

Participating hospitals are New Rochelle Hospital, New Rochelle, N. Y.; Flushing Hospital and Dispensary, Flushing, Queens; Monmouth Memorial Hospital, Long Branch, N. J.; Fitkin Memorial Hospital, Neptune, N. J.; St. Luke's Hospital, Newburgh, N. Y., and North Country Community Hospital, Glen Cove, L. I.

Under the new program, young attending physicians of the participating hospital staffs will have a year's study at the college of medicine after a full year of hospital work at the university's expense. Residence and maintenance expenses will be paid by the hospitals. During this period members of the college faculty will make monthly visits to the cooperating hospitals to organize and participate in conferences, seminars and other academic activities requested by the hospital staffs.

The plan is aimed at providing continuing educational interest for physicians for the first five years following graduation. "It is during these years," Dr. de la Chapelle said, "that the young physician acquires habits and methods of work which will determine his professional success or failure. It is important that the medical school assume responsibility for added training of the young doctor during these formative years."

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National Mental Health Program Starts Awarding Federal Grants

WASHINGTON, D. C.—Hospitals, clinics and numerous universities were among those receiving first federal grants, announced July 28 by U. S. Public Health Service, for training mental health personnel under the new National Mental Health Act.

The grants will be used in these various institutions to support their training programs in the fields of psychiatry, clinical psychology, psychiatric social work and psychiatric nursing.

The national mental health program authorized by Congress last year was implemented early in July with an appropriation of $7,500,000. The program calls for activity in the training of urgently needed personnel and two other major fields: (1) research into the problems of mental health and increased support and (2) stimulation of state efforts to develop adequate mental health programs. Emphasis in state efforts will be placed on prevention and early treatment.

Something like $400,000 will be spent during the fiscal year 1948 for research. In addition to hospitals, universities and clinics, grants-in-aid are provided to other public and private institutions, to laboratories and to qualified individuals. With these grants, 25 research projects will be conducted in such fields as biochemistry, neurophysiology, delinquency, child psychology, alcoholism, psychosomatic medicine, psychotherapy and shock therapy.

The fund also provides research fellowships in fields related to mental health. Fourteen have already been awarded.

More than $1,000,000 will be spent for grants to public and other nonprofit institutions for the development and improvement of facilities for training mental health personnel. Grants include 17 in the field of psychiatry; 16 in clinical psychology; 9 in psychiatric social work, and 9 in psychiatric nursing. Covered by this fund, too, are training stipends for 70 graduate students in psychiatry, 41 in clinical psychology, 40 in social work and 58 in psychiatric nursing.

A sum of $3,000,000 is appropriated for grants-in-aid to states for mental health programs. The Public Health Service has set a goal in the grants to states program of the establishment by the states of one outpatient mental health clinic for each hundred thousand population and provision of services to sparsely settled and rural areas through traveling clinics.

The establishment of in-service training programs and training institutes for general practitioners is also planned in several states. Personnel will be lent to the states on request to aid with their local programs. Demonstration clinics operated by the Public Health Service are contemplated.

State programs and budgets are now being received and grants are being allocated as soon as the plans are reviewed and approved.

The remainder of the funds appropriated will be used for field studies in mental hygiene and the operation of the U. S. Public Health Service hospitals for drug addicts and the mentally ill at Lexington, Ky., and Fort Worth, Tex.

In addition to the appropriations for mental health, the Independent Offices Appropriation Act provides $850,000 for the purchase of a site and the drawing up of plans and specifications for a National Institute of Mental Health to be located in the vicinity of the District of Columbia.

Sydenham Pioneers in Study of Community Ills

NEW YORK.—Sydenham Hospital, which nearly four years ago pioneered in the establishment of an interracial staff for an interracial clientele, announced last month another experiment designed to broaden the institution's community rôle.

The hospital has set up an Institute of Community Relations, headed by a social scientist, and has mapped a tentative program of study into the diseases, both physical and social, of the area. The methods of the sociologist as well as those of the medical man will be employed in the project.

The program is said to be something new for a hospital and an important advance in the field of medicine. For the first time in this country, said Dr. Alfred E. Cohn, a director of Sydenham Hospital, the study and care of sick individuals and the study of the ills of a community will be carried on under one roof.

Heading the new project will be John A. Morsell, former research associate of the Bureau of Applied Social Research at Columbia University. Working with him will be staff physicians, psychiatrists, psychologists and graduate students from Columbia's department of sociology, which will serve in a technical consultant capacity.

Survey Shows 59% Rise in New York Hospital Costs

NEW YORK.—A definite upward trend in demand on New York City's voluntary hospitals was seen as a result of a special study reported by the United Hospital Fund recently.

The study showed an increase in the number of days' care given patients in all levels of hospital service, with marked increases in the demands on voluntary hospital wards and outpatient departments. Many persons in need of hospital care and treatment, faced with current high costs of living, must resort to free or less-than-cost care provided by voluntary institutions, the report said.

The study also showed a steady increase in operating costs of hospital services during the first half of the current year. The cost of all inpatient care in the first six months of 1947 increased 14 per cent over 1946, the report indicated. With 1943 used as a base year, when the average cost per patient day was $8.34, the current cost of $13.27 for identical service shows a startling increase of 59 per cent.

Similarly, the cost per patient visits to clinics of the voluntary hospitals during the first half of 1947 increased 13 per cent over 1946 and 46 per cent over 1943.

Interns and Nurses Excluded From Appropriation Act

WASHINGTON, D. C.—Signed by the President August 4 was the bill which would exclude certain interns, student nurses and similar student employes from various federal laws relating to the compensation and benefits of federal employes. At present a number of these student-employes are engaged in study and training in hospitals, clinics and laboratories operated by the federal government or by the District of Columbia.

Administrative rulings under existing law have hitherto required that these student-employes be treated the same as regular government employes and be compensated for all the hours they are on duty, even though many of these hours are spent in study and training. In order to complete their training in accordance with the standards established by the various professions, the student-employes are required to be on duty for longer hours than the regular staff or other true employes of the government.

The new law excludes student-employes from the Civil Service Retirement Act and from the provisions of annual and sick-leave laws. It does provide, however, that the terms and conditions of service and training, including the granting of sick leave and vacations, with or without pay, are to be prescribed by the head of the agency concerned.

Nuclear Research Man College Banquet Speaker

CHICAGO.—Approximately 20 candidates will be received into fellowship, 90 will be advanced to membership and 129 enrolled as nominees at the 13th annual convocation of the American College of Hospital Administrators in St. Louis, September 21, Dean Conley, executive secretary, said in a preconvention announcement.

Honorary fellowship will also be conferred upon several candidates, including Capt. Joseph E. Stone, consultant on hospital finance, King Edward's Hospital Fund for London, England. Dr. Stone, previously designated honorary fellow but unable to come to the United States to receive the distinction owing to war conditions, will attend this year's meeting and receive the honor.

Dr. Charles Allen Thomas, president-elect of the American Chemical Society, will be the guest speaker at the annual banquet following the convocation. Dr. Thomas is an expert in the field of nuclear research.

The four day meeting of the college will open September 20, with a luncheon for the board of regents, followed by an executive committee meeting. The general educational session at 9 o'clock September 22 will be devoted to the work of the joint commission on education. Robert H. Bishop Jr., M.D., administrator of University Hospitals, Cleveland, Ohio, and chairman of the joint commission on education will be in charge. Officers will be elected at the general business session September 22 and will be inducted at the close of the business session.

Army Now Has Own Medical Service Corps

WASHINGTON, D. C.—A medical service corps was set up as part of the regular army with the signing August 5 by the President of legislation which brought about this change in the permanent organization of the medical department of the army. The new law makes it possible for the first time to give regular army commissions to specialists in the scores of fields now closely allied to medicine.

Grouped together in a new corps under the medical department will be bacteriologists, entomologists, psychologists, sanitary engineers, pharmacists, chemists, electronics experts and the like. Up to now the medical department has been made up of six corps: medical, nurse, women's medical specialists, dental, veterinary and pharmacy.

Heretofore, it has been possible to commission specialists in other fields only in the reserve from which they could be called to service in a national emergency.

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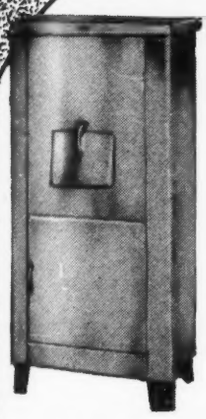

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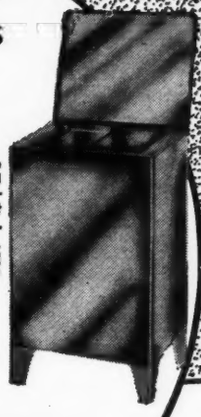

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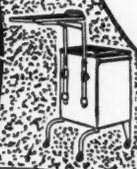

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	36"x36"	21.50	23.00
	30"x42"	21.50	23.00

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Minnesota Association Studies General Duty Nurses' Demands

MINNEAPOLIS.—More than 100 hospital administrators attended a special meeting of the Minnesota Hospital Association here last month to consider minimum employment standards for general duty nurses presented by the Minnesota Nursing Association.

The association did not take final action on the nursing standards at this meeting but voted to study the recommendations further with a view to advising statewide action by hospitals at the earliest possible moment.

Minimum employment standards specified by the nurses' association in its communication to hospitals included a $190 a month salary base for general duty nurses, hospitals to have such employes on a 44 hour week by Oct. 1, 1947, and on a 40 hour week by Jan. 1, 1949. By April 1, 1948, the salary should be advanced to $200 a month with a $5 a month increase after six months of service, $10 after a year of service, and $20 after two years of service and extra compensation for night shift and for duty on communicable and psychiatric cases.

Further demands presented by the nurses' association had to do with maintenance perquisites, extra pay for overtime, paid holidays, vacations, sick leave, breakage, health services and retirement privileges.

"It was evident that the increases requested could not be met without passing at least part of the cost on to the public," an official association statement issued at the meeting said, "and many administrators feel that their patients have already reached the limit of ability to pay for needed care. Therefore, this is definitely a problem affecting the public and one that justifies serious consideration from many angles.

"It was further evident from the reports made by those present," the hospital statement continued, "that the salaries of general duty nurses have been raised on the average of around 125 per cent within the last eight years, during the time when the cost of living, according to the index from Minneapolis, has increased only 51 per cent. However, the feeling of the group was that since salaries eight years ago were substandard the increase now asked may still be fully justified even though those already granted seem fairly high in comparison with the cost of living.

"The hospitals feel that they have a responsibility for public health problems in the state and must try to uphold the interests of the public in the matter of distribution of hospital service so that medical care can be provided at a cost which the public can meet. The group felt that the nurses would fully recognize these points and would work with the association in solving the problem."

A.H.A. Directory Out

CHICAGO.—According to a survey printed in the 1947 edition of the *American Hospital Directory,* published last month by the American Hospital Association, 15,675,602 patients were admitted to 6125 hospitals in 1946, in addition to 38,000,000 visits to clinics by outpatients. Hospital plants were valued at $4,400,000,000, or approximately $3100 per bed, an increase of $180,000,000 over hospital valuation in 1945. In addition to its statistical and financial report on hospitals in 1946, the directory also contains full information on nearly 7000 hospitals in the United States and Canada, including names of administrative personnel, departments, number of admissions and beds and accreditation.

CORRECTION

On page 160 of The MODERN HOSPITAL for August, the price of "A History of the American Medical Association," by Morris Fishbein, M.D., is incorrectly stated as $15. The price of this volume, which is published by the W. B. Saunders Co., Philadelphia, is $10.

Wartime Program of E.M.I.C. Closing With High Record

WASHINGTON, D. C.—The emergency maternity and infant care program is being closed with a record of 1,421,000 cases completed or approved for care from March 1943 to June 30, 1947, the U. S. Children's Bureau announced last month.

The wartime program under which maternity care was provided for servicemen's wives and medical, hospital and nursing care for their infants is being liquidated after more than four years' operation. The books will not be finally closed, however, for at least another twenty-one months, for the full term of care is still to be provided for all wives and infants now receiving care, and for all those eligible for care as of June 30.

The program has been drawing to its end for some time, the bureau reported. Cases accepted for care under the program dropped to an average of 9300 a month in 1947, in comparison with 47,000 during the peak month of the war period. Of the current average monthly cases authorized, 5500 are for maternity care, the remainder being for the care of infants. From the beginning of the program to June 30 this year, infants for whom care has been authorized totaled about 217,300; maternity cases, more than 1,203,500.

In directing the program's liquidations, Congress specifically continued the program for all wives and infants for whom care is already authorized and also brought under the program any serviceman's wife and child if she was pregnant June 30, 1947, even though application had not been made before that time. She can apply for and receive for herself and infant the full services provided for under the E.M.I.C. program until the child is one year of age. Applications can be made to her own physician or to the local or state health department.

There is one exception to the foregoing. Arkansas will not accept any applications made after May 31, 1947.

Cases authorized from time of approval of State plan through June 30, 1947

State	Cases authorized to June 30, 1947		Federal Funds Allotted to States to June 30, 1947
	Maternity	Infant	
U. S.....	1,203,560	217,290	$124,903,231
Ala	19,720	1,660	1,576,777
Alas.....	575	115	73,981
Ariz.....	7,700	1,725	735,935
Ark.....	19,480	1,720	1,558,054
Calif.....	96,560	9,770	11,146,751
Colo.....	13,970	2,100	1,277,007
Conn.....	13,400	4,225	2,009,720
Del.....	2,825	535	365,846
D. C.....	10,540	2,300	1,052,748
Fla.....	24,660	2,005	1,899,287
Ga.....	22,170	1,720	1,666,910
T. H.....	2,895	465	298,200
Ida.....	5,990	1,555	606,783
Ill.....	61,630	12,000	6,673,163
Ind.....	34,515	7,400	3,665,432
Iowa.....	21,215	5,080	2,307,769
Kan.....	22,790	5,650	2,119,468
Ky.....	24,780	2,505	1,902,565
La.....	18,755	4,480	1,734,564
Me.....	7,850	875	735,822
Md.....	16,580	3,230	1,781,327
Mass.....	32,890	9,450	4,245,742
Mich.....	43,890	8,400	5,194,425
Minn.....	22,810	7,030	2,591,624
Miss.....	19,740	3,530	1,557,740
Mo.....	35,290	6,225	3,176,121
Mont.....	5,100	2,080	542,719
Neb.....	14,140	3,960	1,585,445
Nev.....	2,270	365	202,778
N. H.....	4,430	630	461,192
N. J.....	30,575	4,510	3,491,009
N. M.....	8,430	1,670	702,484
N. Y.....	103,730	33,300	14,739,218
N. C.....	38,620	3,350	3,357,399
N. D.....	3,210	1,830	386,167
Ohio.....	54,745	5,720	6,091,561
Okla.....	28,460	1,970	2,356,806
Ore.....	12,510	1,760	1,412,811
Pa.....	69,790	12,010	6,694,385
P. R.....	5,730	1,010	508,561
R. I.....	6,230	1,065	664,864
S. C.....	19,650	2,760	1,640,837
S. D.....	5,660	1,765	621,263
Tenn.....	17,280	2,180	1,360,508
Tex.....	65,150	6,900	5,542,682
Utah.....	10,545	1,740	1,057,833
Vt.....	3,110	2,700	385,623
Va.....	22,630	6,815	2,151,541
Wash....	25,625	4,600	2,856,484
W. V.....	16,860	2,660	1,571,421
Wis.....	23,360	3,720	2,353,965
Wyo.....	2,500	470	209,914

Holds Mass Meeting to Acquaint Public With Hospital Costs

CINCINNATI.—A mass meeting aimed at providing the public with an explanation of rising hospital costs was held in Good Samaritan Hospital auditorium August 13 under the sponsorship of the Southwest Ohio Hospital Association.

Everett W. Jones, vice president of The Modern Hospital Publishing Company, was the principal speaker. Several hundred persons attended the meeting, including trustees of a number of Cincinnati hospitals and representatives of southwestern Ohio newspapers which featured stories explaining the hospital situation.

Individual hospital administrators presented figures indicating how drastically operating costs have risen in recent months.

"The public does not realize the vast service performed by hospitals," Mr. Jones said in his address. "You could close churches or even schools," he continued, "but what would happen if you closed hospitals? The death rate would climb fantastically. We can't afford to let hospitals close but right now many of them can't afford to stay open."

Asserting that hospitals like any other business must remain financially sound, Mr. Jones concluded that increases in rates charged for hospital service were mandatory.

Medical Students Don't Return to Practice in S. D.

SIOUX FALLS, S. D.—Only 11 per cent of the students who have been graduated from the two year medical school at the State University of South Dakota have returned to South Dakota to practice after finishing their medical education, Dr. W. L. Hard of the university's medical school reported last month. The chance of South Dakota's own medical students returning to their home state to practice is only about 1 in 10, Dr. Hard said, whereas states having four year medical schools find that from 50 to as high as 72 per cent of their graduates stay in those states to practice after graduation.

From 75 to 90 per cent of South Dakota's premedical students may never obtain admission to a medical school, Dr. Hard predicted, because there are more than 73,000 applications for only about 6200 openings in the existing medical schools today, or 11 applicants for each vacancy.

Some doctors have come into the state since last year, Dr. Hard stated, but he charged that most of them have settled in the urban centers of the state where the ratio of doctors to people is already favorable. South Dakota's ratio is one of the lowest in the nation, according to a report of the state health committee.

Will Build Only Outer Shell of Unit at Present

CLINTON, MASS.—Trustees of Clinton Hospital voted at a recent meeting to continue the hospital's building program for the construction of a new 77 bed unit including private, semiprivate and ward beds, also modern auxiliary services and administrative offices.

It was, however, decided at this time to construct only the outer shell of the building, enclosed by roof, windows and doors, and incorporating conduits and sleeves for future wiring and piping. The decision of the trustees was influenced by present day high and unsettled building costs, especially those pertaining to the mechanical trades, scientific equipment, furniture and fixtures. By the time the outer shell has been completed, it is believed, there will be a clearer indication of market stabilization in the cost of the finishing operations that will be required to complete the building and its facilities.

A.C.S. Standardization Conference Features Hospital Medical Service

NEW YORK.—Current problems in medical service in hospitals is the principal topic for discussion at the 26th annual Hospital Standardization Conference of the American College of Surgeons at the Waldorf Astoria Hotel in New York, Sept. 8 to 11. Specific topics for discussion include integration of the general practitioner in the hospital staff organization, medical audits, classification of surgeons, staff conferences and use of the medical library for graduate medical education.

Speakers include Dr. Joseph Turner of Mount Sinai Hospital, New York, Dr. Frederick T. Hill of Waterville, Me., Dr. J. J. Golub of New York and Dr. Joseph C. Doane of Philadelphia.

Also featured at the conference this year is a joint session for hospital trustees, medical staff officers and administrators. Raymond P. Sloan, editor of The MODERN HOSPITAL, is chairman of this session, which includes discussion of regional hospitalization plans, training of hospital administrators and cooperation among trustees, medical staff and administration.

Other topics to be discussed at the conference include nursing service in hospitals, personnel relations, training of medical record librarians, education of interns and residents in surgery and special problems of the small hospital.

These Federal Bills Lost in the Shuffle

WASHINGTON, D. C.—In spite of the fact that S. 1423, the bill recently introduced to enable states and local governments to plan for the construction of public works, had a friendly reception among Congressmen, it got lost in the last minute shuffle, an official of Federal Works Agency said August 8.

Hearings on health legislation, S. 545, to create an independent national health agency, and on S. 1320, compulsory health insurance, lasted through July 23. Further hearings were postponed until January 1948.

The bill to create an executive department of the government to be known as the Department of Health, Education and Security was reported favorably out of the Senate committee on expenditures but remained among bills unenacted in the first session of the 80th Congress.

Action on broadening social security coverage to reach many not now covered was deferred.

Unenacted was the provision for membership and participation by the United States in the World Health Organization.

Dr. Sayers on Leave to Advise U.M.W. on Welfare and Retirement

WASHINGTON, D. C.—Dr. R. R. Sayers, medical director of the U. S. Public Health Service and director of U. S. Bureau of Mines since 1940, has been granted leave without pay to accept the chairmanship of the medical board established last week by the trustees of the Welfare and Retirement Fund of the United Mine Workers of America. His appointment was announced last month by Dr. Thomas Parran, surgeon general, U. S. Public Health Service.

Assignment of Dr. Sayers to this position is in line with Public Health Service policy of making expert personnel available to official and voluntary, nonprofit organizations to assist in the developmental stages of new and significant health undertakings, the Surgeon General stated.

In his new position, Dr. Sayers will advise trustees of the miners' fund on health and medical problems. He will also assist state and local public health authorities, as well as coal operators and unions, in carrying out recommendations contained in the medical survey of the bituminous coal industry issued last spring by R. Adm. Joel T. Boone. This survey, provided for by the Lewis-Krug agreement when the government was operating the mines, is the first nationwide report on living and working conditions of miners. Its recommendations include:

Establishment of strong local health departments; improvement of basic sanitation; organization of health education programs, including health demonstration projects by medical societies or philanthropic foundations; industry-wide studies and research on nature, occurrence and control of occupational diseases and disabilities; rehabilitation programs; expansion of company industrial medicine programs, including physical examinations of employes, and provision of adequate first aid and other medical facilities; improvement of size and quality of hospitals and outpatient clinics; modification and consolidation of prepayment plans for medical care, and improvement of housing and of recreational facilities.

These and other recommendations of the survey call for close cooperation among miners, operators, medical societies, health organizations and federal, state and local official agencies. To implement their work, the survey recommended that "an outstanding leader of the civilian profession be on any trusteeship established for medical care and hospitalization." Dr. Sayers' appointment is in line with the latter recommendation.

Marietta Campaign Successful

MARIETTA, OHIO.—A campaign for $350,000 for expansion of Marietta Memorial Hospital was successfully completed last month with a total of $389,000 subscribed. The campaign was undertaken to relieve the overcrowded conditions at the hospital, which serves a population of about 60,000 in Washington County and surrounding areas. Plans call for doubling the original capacity of the hospital, which was built in 1929 with 54 beds. A new four story wing will provide, in addition to more rooms for patients, new surgical department facilities, a new laboratory, a new x-ray department, a new entrance and business office. Construction of the wing will also make possible expansion of the obstetrical department.

Blue Cross Reaches 28,000,000

CHICAGO.—More than 28,000,000 persons in the United States and Canada now are covered by Blue Cross hospital service, Richard M. Jones, Blue Cross Commission director, stated August 20, in announcing second quarter enrollment results. Leaders in enrollment growth were New York City, Boston and Chicago which reported, respectively, second quarter gains of 148,471, 129,945 and 76,987, Mr. Jones said.

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New York Devises Master Plan for Tuberculosis Control

NEW YORK.—Pointing out the value of early detection in helping to bring tuberculosis under control, the Hospital Council of Greater New York last month presented details of its master plan recommendation that general hospitals provide facilities for the diagnosis and treatment of this disease.

The council advised the establishment of 6600 beds in New York City by 1950 for the treatment of tuberculosis and further recommended that general hospitals "include provision for the diagnosis and study of suspected cases of tuberculosis, for the surgical treatment of the disease and possibly for cases requiring reevaluation."

The report also said: "The essential and signicant advances in the control of tuberculosis were made when early detection of the existence of the disease in the individual was possible. In the complete program to eradicate this disease, the care of patients with tuberculosis must include the necessary diagnostic procedures to detect the presence of the disease, as well as the therapy directed toward the cure."

The council recommended the establishment of 800 beds in general hospitals by 1950 for the care of tuberculous patients. According to the report, these beds would be distributed in units of 50 beds each in the central hospitals and in units of from 5 to 10 beds in each of the regional and community hospitals called for in the master plan.

The report explained that the remainder of the beds needed for tuberculosis care, or 5800 beds, should be established in hospitals primarily for the care of tuberculous patients. The report cautioned, however, "that hospitals established primarily for the care of patients with tuberculosis be located in or near the city. . . . Proximity to the city and accessibility to relatives and physicians appear to be important factors in assuring adequate care to patients requiring hospitalization."

Stressing the fact that many patients discharged from the tuberculosis hospitals leave against medical advice, the council's report said: "It is significant to note that many of these patients were active carriers of tuberculosis at the time of their departure from the hospital. This factor alone can materially retard the ultimate success of the campaign to bring this disease under complete control. In planning for facilities for the care of tuberculous patients, the factors which impel patients to this course must be given thorough consideration."

Allowances Increased for Disabled Vets

WASHINGTON, D. C.—Automatic increases became effective September 1 in the minimum allowances received by the more seriously disabled veterans enrolled in educational and training courses. The increased rates were voted by the last session of Congress.

The new law provides that a veteran enrolled in a course under Public Law 16 whose disability is rated at 30 per cent or higher will receive $115 a month if he has no dependents and $135 if he has one dependent. The old law allowed $105 and $115 for the same two categories.

College of Pathologists to Meet

CHICAGO.—The first general meeting of the College of American Pathologists will be held in Chicago October 27 to 29, Dr. M. G. Westmoreland, executive secretary, announced last month. Members and fellows of the newly organized college will be formally inducted and the board of governors will present a review of the progress made in organization. The meeting will be held simultaneously with the American Society of Clinical Pathologists.

Doctors in Federal Services Given More Compensation

WASHINGTON, D. C.—Effective September 1, an additional $100 a month will be paid to regular army and navy medical and dental corps officers as well as to doctors in the Public Health Service.

The so called "ham and eggs b'll" making this rise in pay possible was signed into law early in August. A provision to pay specialists in the various fields of medicine in these services an additional 25 per cent increase in their base longevity pay was dropped from the legislation.

Army's Surgeon General Bliss has emphasized that this addition to the incomes of medical and dental officers is regarded by the War Department "not as a pay increase but as an equalization measure designed to bring the incomes of medical and dental corps officers more nearly in line with those of civilian doctors and dentists." The army will follow a new policy of commissioning selected doctors and dentists in grades as high as full colonel depending upon their age and professional qualifications.

The increase in compensation will benefit not only regular army but also reserve, National Guard and Army of the United States officers. Former students of the Army Specialized Training Program who are required to serve on extended active duty are eligible for this increase in compensation when they apply for and are accepted into the regular army.

The enabling legislation limits the duration of these benefits to thirty years of active service.

A.H.A. Plans Institute on Laundry Operation

CHICAGO.—A growing tendency for hospitals to do their own laundry in the face of increased costs of commercial laundries has prompted the American Hospital Association to sponsor an institute on laundry operation October 6 to 9 at the University of Iowa, Iowa City.

Kenneth Williamson, assistant director, said the program for the meeting had been drawn up at a meeting of the laundry management committee, which includes representatives of commercial laundries. Subjects to be covered include washroom practice, linen control, textiles and classification, standards of production, time and motion study, working environment and motivation, relation of the laundry to total operation of a hospital, contaminated linen, testing and demonstrations, equipment planning and care and comparative costs.

Other points in the general program recommended by the committee were publication of a manual of laundry operation and an education program for administrators and other hospital personnel.

Attendance at the institute will be limited to 100 persons, either personal members of the American Hospital Association or representatives of institutional members of the association.

New Georgetown Hospital Opens Doors to Public

WASHINGTON, D. C.—Georgetown University opened the doors of its new hospital July 31. Built at a cost of $3,600,000, the hospital has increased the bed capacity from 241 to 407 and has provided an expanded outpatient department. It has doubled its beds for expectant mothers and furnishes special facilities for premature babies.

A children's wing, made possible by a $55,000 donation from C.I.O., is a living memorial to the late Franklin D. Roosevelt. The hospital boasts a diagnostic clinic where the latest laboratory technics will be made available.

Dean of the new medical center is the Rev. Paul McNally; hospital administrator is Sister Mary Antonella.

V.A. Urges Residents to Accept Appointments on Probational Basis

WASHINGTON, D. C.—Veterans Administration is encouraging doctors who complete residency training in a veterans' hospital to accept full time probational appointments in the Department of Medicine and Surgery, Dr. Paul R. Hawley, chief medical director, announced August 18. Appointments are made permanent upon satisfactory completion of three years' probational work. An effort is made to place these doctors where they may practice their specialties.

Veterans Administration offers doctors serving in V.A. hospitals, both during and after completion of residency training, the guidance of certified specialists in the practice of their specialties. Such additional practice under the guidance of certified specialists is required of doctors upon completion of formal residency training of American specialty boards.

V.A. has training programs under way in 62 of its 124 hospitals, with 1770 residents studying for their specialty boards.

Public Quick to Patronize Cancer Prevention Center

NEW YORK.—The Hospital for Joint Diseases here served 26,105 patients during the past year, according to the 40th annual report, just released. The number included 5872 bed patients and 20,233 ambulatory patients. During the last year, the hospital beds were fully occupied, and on the average day during the entire year there have been 200 bed patients waiting to be admitted to the hospital.

The report also stated that during the year the hospital added a new service, the Cancer Prevention and Detection Center. Purpose of the center, it was explained, is to submit people who apparently are in good health to a thorough physical examination, including a series of special laboratory tests by competent physicians and scientists aiming at a careful search for the possible beginnings of malignant growth and other diseases. The center encourages people with no symptoms or physical signs of any disease whatever to come for a physical examination.

Although the center has been opened only since June 26, 1946, the report said, 496 patients have been examined and several hundred others are awaiting appointments for such examinations. Judging by the character of the service and the growing waiting list, the demand for the service is growing rapidly.

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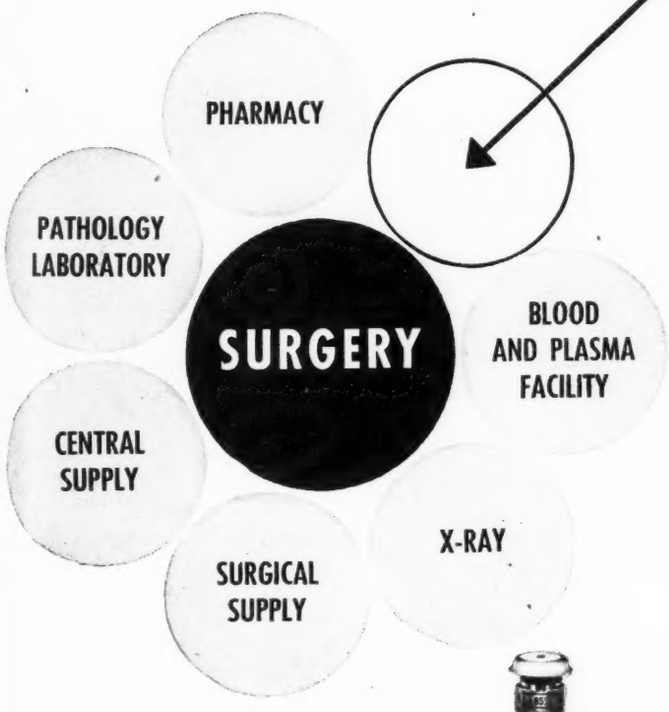

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Notes First Anniversary of Distribution of Radioisotopes for Research

WASHINGTON, D. C.—One year ago on August 2, the first sale of a beneficial radioactive isotope was made to the Barnard Free Skin and Cancer Hospital in St. Louis, the Atomic Energy Commission reported recently.

On the first anniversary of that occasion, production of more than 100 varieties of radioisotopes continues at an unprecedented rate. Clinton Laboratories operated for the government by the Monsanto Chemical Company has in the first year made 1092 shipments of radioactive elements.

During the last year, isotopes have been used in research work in fundamental and applied sciences, particularly in biology and medicine. Nationwide distribution of the materials has been coordinated and supervised by the advisory committee on isotope distribution policy.

All requests for radioactive materials to be used for medical study are referred to a committee on human applications composed of physicians and scientists not connected with the Atomic Energy Commission.

Iowa Has New Type of Ambulance in Fleet

IOWA CITY, IOWA.—A new type of passenger vehicle has recently taken its place beside the standard ambulances of the University of Iowa Hospitals fleet. A stock model of heavy duty design costing $1800 to $4000 less than custom made ambulances, the new conveyance has been fleet tested under trying conditions and has proved itself ideally suited to the task of providing ambulance service over the entire state, Gerhard Hartman, hospital superintendent, announced.

One of University of Iowa's new ambulances

The interior design permits a patient to be carried in a reclining position on an ambulance cot, accompanied by a driver and four other passengers. When not in use, the cot folds out of the way to make room for a total of eight passengers in addition to the driver.

Since the inauguration of the University Hospitals fleet in 1932, a saving of hundreds of thousands of dollars to the taxpayers has been achieved by the use of hospital owned ambulances rather than other means of transportation for indigent state patients, Mr. Hartman said. Even greater economy is contemplated with the new cars as a result of lower operating and maintenance costs, he added.

A.H.A. Accounting Institute

CHICAGO.—Accounting and business office procedures will be subjects of an institute to be conducted by the American Hospital Association October 20 to 24 in Asheville, N. C., it was announced last month.

Practical topics will be discussed by an outstanding faculty, and emphasis will be given to basic underlying theories of hospital bookkeeping and accounting, according to William H. Markey Jr., staff accounting specialist. Discussions of various patient and public contacts made by hospital business employes will also be featured.

Registration will be limited to 100 persons who must be accountants, bookkeepers, administrators or others employed in the accounting and business offices of hospitals.

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Consider Residencies in Germany for U. S. Army Doctors

WASHINGTON, D. C.—Maj. Gen. Raymond W. Bliss, surgeon general of the army, just returned from inspecting American medical military installations beyond the Rhine, contemplates setting up a residency training program for young American medical corps officers now stationed in Germany, according to an announcement of the War Department.

Gen. Bliss would like to see these young doctors exposed to the vast amount of clinical material available in German civilian hospitals. German medicine, he said, has fallen to an almost unbelievably low estate. Many of the hospitals and laboratories are in ruins. Some of the foremost physicians and medical scientists are still in concentration camps. There is an extreme shortage of everything needed to care for the sick.

The U. S. Army doctors are acquiring only limited experience in treating American soldiers in excellent physical condition. A cooperative program would help both the army doctors and the German patients, Gen. Bliss observed.

V.A. Accepting Bids on N. P. Hospital at Lebanon

WASHINGTON, D. C.—The Veterans Administration is accepting bids for construction of a 564 bed neuropsychiatric addition to its hospital at Lebanon, Pa., it was announced recently.

Plans may be obtained after September 2 from the Director of Construction, Veterans Administration, Washington 25, D. C. Bidding deadline is 1:30 p.m., October 14, when bids will be opened.

Plans call for an administration building, medical rehabilitation building, disturbed ward building, chapel, recreation building, an addition to the present laundry and boiler house and quarters for the manager, officers, residents, interns and attendants. The buildings must have concrete foundations, reinforced concrete floors, built-up slate roofs and brick faced exterior walls with stone trim, backed by hollow tile.

Two categories of bids will be considered. One must include all the following items of construction: buildings, roads, walks, drainage, plumbing, heating and electrical refrigeration equipment. The other must include electric elevators and dumbwaiters.

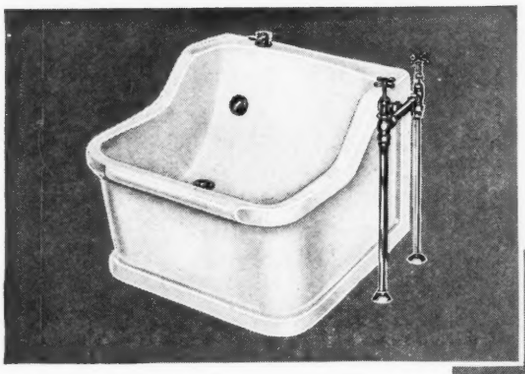
The Lebanon hospital now contains 212 beds for general medical and surgical cases and 265 beds for neuropsychiatric veteran patients.

More Surplus Cotton Duck and Tent Twill Offered

WASHINGTON, D. C.—An additional inventory of about 2,500,000 yards of war surplus cotton duck and tent twill was offered in a national sale from August 18 to September 8 by War Assets Administration. The usual priority sequence was followed in the sale of the duck and twill of weights, widths and finishes not previously offered. The concurrent sale was held in addition to a continuous fixed price sale of these items now under way on a first-come basis in the New York office. The remaining yardage in this sale is of weights, widths and finishes already made available to priority claimants.

Laundrymen to Atlantic City

YPSILANTI, MICH.—Hospital laundry managers are urged to attend the National Association of Institutional Laundry Managers annual convention in Atlantic City the week of November 3, according to an association announcement last month. "We have an extensive and concentrated educational program arranged," the association said, "aimed at finding ways to achieve greater production at lower costs, savings in linen and generally better managed laundries."



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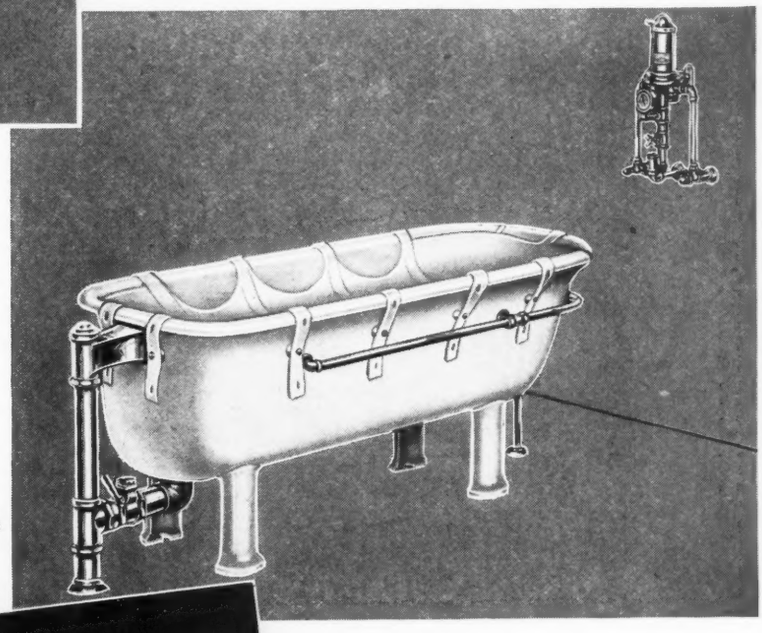

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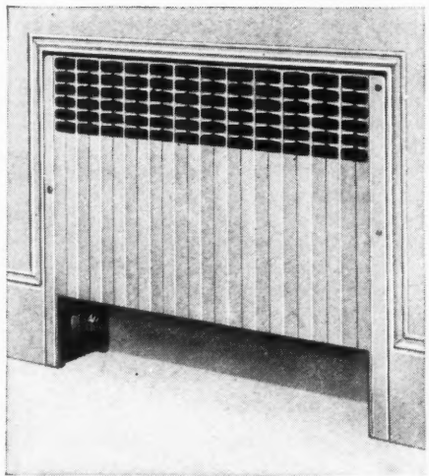

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F. W. A. Approved Advances of $4,000,000 for Hospital Planning

By HARRY HEWES

WASHINGTON, D. C.—Advances aggregating $3,914,747 for the preparation of plans and specifications for 225 hospitals and health center projects were approved by the Federal Works Agency's advance planning program for local public works which expired with its parent legislation, the War Mobilization and Reconversion Act of 1944. Estimated cost of the proposed public health facilities is $133,923,098, contained in projects in 38 states and Hawaii.

Remaining under review in F.W.A.'s bureau of community facilities were applications for advances of $1,597,161 for plan preparation of 55 other hospital projects which would cost an estimated $42,229,491. Working drawings and blueprints for 39 projects had been completed. They will cost approximately $10,399,234.

Funds provided for planning preparation, under the terms of the act, are to be returned, without interest, into the U. S. Treasury when construction is started. No federal grants were made in this program. Appearing before a Senate committee on July 11, Maj. Gen. Philip B. Fleming, Federal Works Administrator, stated only repayable advances had been made and that "we thoroughly expect to get our money back."

"No advances were made," he added, "unless we were positively assured the local resources were sufficient to pay for the project and that construction could be begun within four years."

Throughout the life of the program it was emphasized that no encouragement would be given to the planning of any but the most useful and needed public works.

Under the Lanham Act and as war public works projects, F.W.A. contributed $86,280,560 for construction and equipment of 870 hospitals or health centers which cost $112,896,585. These were in war impacted communities where local resources had broken down under the pressure of population occasioned by war industry or large military concentrations.

The advance planning legislation for a postwar program was intended to assist in the creation of an adequate reserve of fully planned state and local public works which could be put into construction as economic conditions warranted. The existing reserve is still far from providing preparation to meet these needs. Bills were before Congress late in July providing for appropriations of $50,000,000 a year for five years to carry on a similar program for the advance planning of nonfederal public works.

The large majority of the projects planned in F.W.A.'s recent program are for general hospitals and there are reflected in many of the applications the findings of the state surveys sponsored by the American Hospital Association. The geographical distribution mirrors in some degree the level as well as the amount of medical care available to the population and the recognition that adequate diagnosis and treatment are dependent upon facilities that can be provided only in well equipped hospitals.

Foretaste of Dietitians' Rôle

PITTSBURGH. — Four students majoring in nutrition in Pennsylvania colleges were provided with an indoctrination course in the fundamentals of hospital dietetics at Montefiore Hospital here this summer. They acquired experience in administration, food preparation, special diets, food service to personnel and patients, and food clinic, which includes the interpretation of diets for outpatients. With the actual hospital experience provided them, they were afforded the opportunity to decide whether hospital dietetics is the particular field of nutrition to which they want to devote their interests.

Health Gains Achieved Through War Surplus

WASHINGTON, D. C.—The health interests of the nation have been appreciably advanced by transfers at nominal sums to priority holders of general, mental and tuberculosis hospitals, according to a recent W.A.A. report. Some 30 institutions of this type, costing the government about $85,000,000, have been authorized for disposal to states, counties, cities and nonprofit organizations for health uses. The nation's supply of hospital beds has thus been increased by 16,000.

A packaged hospital, containing 600 bed units with operating room and other vital medical equipment, was made available to Salt Lake City during a severe infantile paralysis outbreak last September. Another of these hospitals went to Alaska where facilities were seriously inadequate.

Medical items of all types and other sorely needed supplies went to Texas City after its catastrophic explosion and fire, to Oklahoma after the recent hurricane and to several flood areas in the country.

Pennsylvanians Study Personnel Relations

STATE COLLEGE, PA.—An institute on hospital personnel relations was held August 15 and 16 at Pennsylvania State College under the sponsorship of the Hospital Association of Pennsylvania. Topics discussed included the significance of personnel in hospital public relations by Raymond P. Sloan, editor of The MODERN HOSPITAL; organization of personnel for catastrophies by Robert L. Gill of Altoona, Pa.; applying sound personnel principles in the hospital by William Donnelly of Greenwich, Conn., and round table discussions of employment practices, personnel shortages, collective bargaining, employe morale and other subjects of interest in personnel management.

St. Elizabeths Seeks Voluntary Entry of Patients

WASHINGTON, D. C.—A bill that would permit residents of the District of Columbia to enter St. Elizabeths Hospital voluntarily will be revived next year, according to Dr. Winfred Overholser, superintendent of the mental hospital, on August 6.

The measure that was drafted by the Federal Security Agency failed to reach Congress this year because the District commissioners opposed it. Dr. Overholser declared that earlier cures might be effected if the ignominy of commitment were abolished.

President Vetoes National Science Foundation Bill

WASHINGTON, D. C.—President Truman on August 6 vetoed the National Science Foundation Bill as fundamentally unsound. His disapproval of the bill as finally submitted by Congress did not come as too great a surprise though he has consistently urged legislation which would establish such a foundation. Objections to provisions of the measure on the part of several members of the cabinet indicated that a veto might be expected.

Outstanding criticism of the bill was leveled at the board composed of part time uncompensated officials, which would meet but once each year. This group would select biennially from its 24 members an executive committee of nine, also a part time body required to meet only six times annually. The foundation would appoint its own chief executive officer and prescribe his duties.

Moreover full governmental authority and responsibility—the determination of vital national policies, the expenditure of large public funds, the administration of important governmental functions—would be invested in a group of individuals who would be essentially private citizens, said the President. He could not effectively hold them responsible for proper administration. He could not hold responsible an administrator, appointed by the foundation and insulated from the President by two layers of part time boards.

Apart from the unwieldy organization prescribed in the bill, the President considered as a serious flaw the fact that the foundation would make grants of federal funds and would determine where those funds would go—to what institutions and organizations. Yet under the terms of the measure, the members of the foundation would be individuals employed by institutions and organizations eligible for such grants. He claimed that a conflict of interests would inevitably develop and give rise to suspicions of favoritism.

Cites Desperate Need for Convalescent Beds in N.Y.C.

NEW YORK.—Seventeen hospital construction projects were included in the municipal budget which was approved last month by the New York board of estimates. Total cost of the projects is approximately $135,000,000.

The 17 projects included in the board of estimates' approval were from an original list of 51 items submitted by Hospital Commissioner Edward M. Bernecker. The complete program called for approximately $350,000,000 worth of building.

In a letter to Mayor O'Dwyer, Commissioner Bernecker said conditions in connection with the care of chronic disease patients in New York were "desperate," with city hospitals filled to overflowing. Other conditions emphasized by Commissioner Bernecker were the need for additional facilities for tuberculosis and for modern laundries.

Ohio State Establishes Department of Radiology

COLUMBUS, OHIO.—Establishment of a new department of radiology in the Ohio State University College of Medicine, with Dr. Hugh J. Means as chairman, was announced last month. In the new department, comprehensive instruction in x-ray work will be provided for graduate and undergraduate medical students as well as for physicians taking refresher courses. Opportunities also will be afforded for independent research, particularly in the newer fields of radiation physics and nuclear physics as they apply to medicine. Such investigations will be supervised by Dr. Means and Dr. Joseph Morton at the University Hospital, and at the university's radiation laboratory by Dr. Theodore J. Wang.

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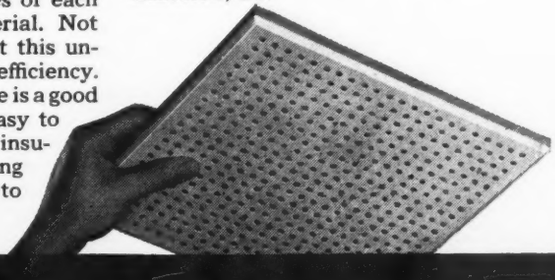

ARMSTRONG'S CUSHIONTONE

Armstrong Cork Company Ⓐ Lancaster, Pennsylvania

Reprint of Advertisement Appearing in Modern Hospital, September—ACL 223

To Build Hospital-School at University of Iowa

IOWA CITY, IOWA.—A $500,000 addition to the University of Iowa Hospitals in the form of a hospital-school for severely handicapped children has been voted by the state legislature.

With an additional $118,000 appropriation for its first two years' operating expenses, the hospital-school will be operated in conjunction with the Children's Hospital, a unit of the University Hospitals, Supt. Gerhard Hartman reports.

The hospital-school will be located in Iowa City and will use the University Hospitals' therapeutic and service facilities. Patients eligible for admission will be children between the ages of 3 and 21 who are educable but too severely handicapped to be cared for through other facilities. Persons between 21 and 35 years of age may also be admitted by special consent of the state board of education. Fifty persons can be accommodated, according to plans.

The Iowa Society for Crippled Children and Disabled, original sponsor of the legislation, found through its surveys that handicapped children, though they needed medical supervision, were not ill enough to require acute hospital care and were not profiting from existing public education facilities. Those severely handicapped by cerebral palsy, muscular dystrophy, spina bifida and similar diseases were not receiving necessary care.

The new hospital-school will not duplicate the work of any existing service, Mr. Hartman said. "This new program of combined education and medical treatment will ensure severely handicapped children an opportunity to become more nearly self supporting," he added. "Without such specialized care, many of these patients would in all probability become custodial cases for the state."

Counseling Service for Public Serves 3000 in First Year

NEW YORK.—The counseling service established by the United Hospital Fund of New York to meet community needs for direction and guidance in the selection of hospital and nursing care facilities has completed its first year of operation, it was announced last month. During the year the fund's counseling service assisted 3000 individuals in all economic groups throughout the city in problems relating to hospitalization, nursing and convalescent care.

Nursing homes, convalescent homes, institutions for the chronically ill and aged, clinics and hospitals are the principal facilities about which persons seek information from the counseling service, it was explained. Variations in admission policies, personnel, program and rates among the homes and institutions are the chief reasons persons seek advice in selecting proper facilities.

New Orleans Now Has Own Eye Bank

NEW YORK.—An eye bank has been organized in the Louisiana State University Medical School and the Tulane University Medical School and Hospital at New Orleans, it was announced last month by the Eye Bank for Sight Restoration. Other affiliated eye banks are functioning in Boston and Chicago, it was reported. The new eye bank is located in the Hutchinson Memorial Building, New Orleans.

The Eye Bank for Sight Restoration and its three affiliated banks collect and preserve healthy corneal tissue from human eyes for transplanting to blind persons who have lost their sight because of corneal defects, it was explained; this tissue is available to surgeons who are qualified to perform the corneal transplant operation. Two other objectives are the training of surgeons in the technic of the delicate corneal graft operation and the furtherance of research studies.

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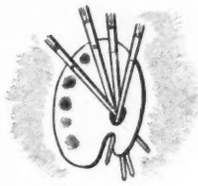

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Medical Service Plan Shows Quick Worth

NEW YORK.—A total of 201,944 persons enrolled in United Medical Service during the first six months of 1947, as against 113,733 during the first six months of 1946, an increase of 88,211 or approximately 77 per cent, Rowland H. George, president, announced last month. The overall enrollment at the end of June 1947 was 607,688.

During the first six months of 1947, 19,845 medical bills totaling $898,093 were paid on behalf of U.M.S. members as against 7795 bills totaling $341,641 for the same period a year ago. Since the organization was founded three years ago, 46,268 bills totaling $2,227,405 have been paid.

Referring to the increased enrollment in U.M.S., Mr. George said: "Our steady and unprecedented growth indicates that the system of voluntary prepaid medical care, now being practiced by 43 nonprofit Blue Cross affiliated medical service plans throughout the United States, has successfully passed the experimental stage.

"Sponsored by medical societies and backed by increasing numbers of employers, voluntary medical plans are steadily gaining the confidence of both the medical profession and the lay public. The successful record of U.M.S. in itself is evidence that we have taken a long step forward toward solving the problem of the cost of medical care just as our Blue Cross affiliate, Associated Hospital Service, is helping to solve the problem of hospitalization costs."

V.A. Recruits Nurses for Sanatorium Work

WASHINGTON, D. C.—Recruitment of nurses for assignment to V.A. tuberculosis hospitals has been intensified with the establishment of a tuberculosis training center at Oteen, N. C. At Oteen, senior cadets, graduate nurses and other hospital personnel learn the latest developments in the care of tuberculous patients, medical and surgical treatment and modern protective methods.

Under V.A.'s policy nurses are appointed to the grades for which they are individually qualified. Those who want to specialize in nursing in tuberculosis or any other clinical field may earn salaries equivalent to those heretofore available only in the field of nursing administration. Salaries range from $2644 to $6000.

Anesthesia School Heads to Meet in Closed Session

CHICAGO.—The shortage of nurse anesthetists and the increasing demand for their services will receive major emphasis at a schools of anesthesiology assembly to be held September 20-21 in St. Louis, prior to the anual meeting of the American Association of Nurse Anesthetists, September 22-25, according to an association announcement. In a closed meeting, the directors of the schools of anesthesia for nurses will pool ideas on ways and means of recruiting student anesthetists and teachers and of increasing training facilities, it was reported. With impetus being given the construction of small community hospitals by the federal aid program, there is an ever increasing need for competent anesthetists in small communities, the association pointed out.

Would Enlarge Mailing List

WASHINGTON, D. C.—In a letter released recently to all regional directors of the War Assets Administration, John R. Campbell, director of the Priorities Claimants Division of W.A.A., requested that hospitals be placed on mailing lists for offerings of surplus property in the following classifications: machinery, hardware, plumbing supplies, paper, furniture, drugs, medical supplies and textiles. The memorandum was accompanied by a list of hospitals served by each of the regional W.A.A. offices.

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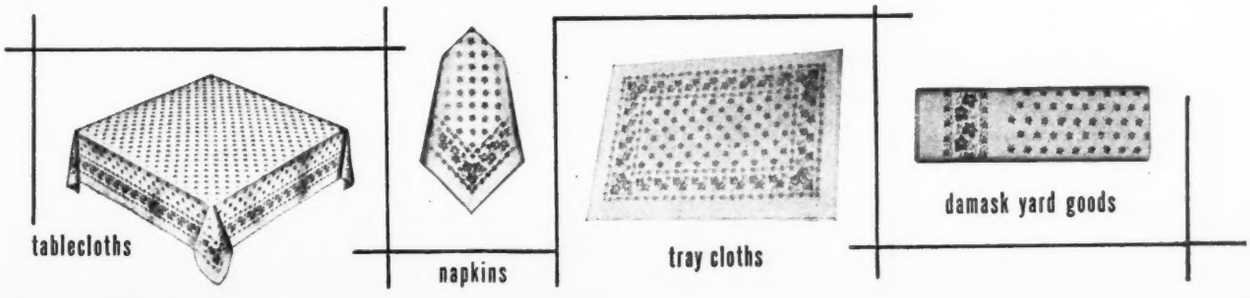

Army Plans Short Training Course for Lay Administrative Personnel

WASHINGTON, D. C.—Administration of military hospitals will be the subject of instruction for lay administrative personnel of the medical department of the army in a twelve weeks' course being established in November at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Texas.

The course as presently outlined will include nine subjects pertinent to military hospital administration and is designed to qualify officers in capacities comparable to the department heads of a civilian institution.

Subjects to be covered in the course are: hospital organization and functions, personnel administration, psychology of leadership, hospital accounting, food service management, military law and applied commercial law, orientation to medical science, organization and functions of the registrar's office and organization and functions of the hospital supply office.

Prewar training of lay hospital administrative officer personnel in the army was by on-the-job training through various hospital departments, a spokesman for the Surgeon General's office explained. This was preceded by general basic training designed to qualify the individual as an officer in general administration of the medical department, particularly in its functions under field conditions.

This program was highly decentralized, flexible and often varied in extent and degree with the individual hospital commander to whose command newly commissioned personnel was assigned for training, it was explained. Though this method resulted in the development of some eminently qualified administrative personnel, it did not offer the advantages of a more centrally planned, coordinated and supervised program.

The present plan proposes a tentative arrangement for rotating internship in certain selected military hospitals where the officer will undergo supervised on-the-job training, with emphasis given to the departments of his selected specialty. The specialties are grouped into four major job titles: supply, food service administration, personnel and administration, and registrar's functions (the registrar in a military hospital is comparable to a medical records librarian in the civilian hospital). All officers will receive some training in the principles and duties of all phases of hospital administration before branching out into more specialized fields, it was stated.

Present plans call for selected subjects in hospital administration to be included in an advanced course which will begin in the fall of 1948. The subjects will be designed to qualify senior officers of the medical department in executive functions of hospital administration, comparable to the medical or lay administrators of civilian hospitals.

In connection with either of the preceding courses, it was pointed out that each student will have had some prior college education in technical and academic subjects, in addition to basic training in the army and some experience in the actual work situation of the job for which he is being trained.

In addition to lay officers, selected members of the Army Nurse Corps will take some of the hospital administration subjects.

"The entire program is directed toward a broadened attainment of knowledge and understanding of the intricacies of military hospital administration in all of its aspects," the announcement from the Surgeon General's office said. "Emphasis will be on the practical features of the material presented, for the army has long recognized that beyond learning lies application."

Fifty Attend Institute on Personnel Management

CLEVELAND.—Approximately 50 hospital administrators and personnel officers from the East and Middle West attended an institute on hospital personnel management sponsored by the American Hospital Association and Western Reserve University in cooperation with the Ohio Hospital Association and the Cleveland Hospital Council here early in August. The faculty for the institute included a number of nationally known authorities in the hospital field and personnel executives in industry.

J. L. Otis, director of the personnel research institute of Western Reserve University, gave an important lecture on the subject of individual worker motivation. Fair working standards, friendly surroundings, pride in the job and similar values are equally important with earning opportunities, Dr. Otis told the group.

Dr. Otis urged those attending the institute to conduct surveys aimed at determining what hospital workers don't like about their jobs as a necessary preliminary to making hospital employment more attractive. He also emphasized the importance of merging worker attitudes toward such things as seniority, merit rating, wage scales and grievance procedures.

Other subjects studied during the four day institute included employe recruitment, placement and training, interviews, job analysis and evaluation and human relations in personnel administration.

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In the hospital buildings of tomorrow, speedy economical erection and greater utility are paramount. Steel joists are ideal for such structures because they are easier to install than wood—pipes and conduits can be concealed within the floor system—shrinkage is eliminated, thus preventing cracking of ceilings and partitions—they are termite proof and fire resistive. For full particulars, see your nearest Ceco office.

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Rhode Island Blue Cross Increases Rates, Benefits

PROVIDENCE, R. I.—Blue Cross of Rhode Island will increase subscription fees approximately a penny per day per subscriber as a result of rising hospital costs, it was announced last month. At the same time, members will be given additional Blue Cross benefits, it was emphasized. Changes will take place November 1.

The decision to increase rates to subscribers followed approval of a new rate structure by the insurance commissioner for Rhode Island. Kenneth MacColl, Blue Cross president, said that in the last two years the charge for minimum priced accommodations in member hospitals has increased by 50 per cent and that the increase in charges for extra services provided by the Blue Cross has amounted to 86 per cent in the same length of time. The new schedule increases overall rates by 35.6 per cent, Mr. MacColl declared, and is the first general rate increase since the plan was established in Rhode Island eight years ago.

Pointing out that Rhode Island Blue Cross members occupy approximately half the hospital beds in the state, Mr. MacColl stated: "The hospitals rightly look to us to do our share in meeting higher costs resulting from the inflationary trend of the times. They cannot give the best possible service to our members unless we make it possible for them to provide it."

Buerki and Lyons Head A.P.H.A. Round Table

EVANSVILLE, IND.—The annual convention of the American Protestant Hospital Association will be held in St. Louis September 19 to 21 immediately preceding the A.H.A. meeting there, Albert G. Hahn, executive secretary, has announced.

Featuring the meeting will be the annual conference of Protestant hospital chaplains. Rev. Russell Dicks, president of the chaplains' section and chaplain at Wesley Memorial Hospital, Chicago, will preside. Speakers include Rev. Granger E. Westberg, Augustana Hospital, Chicago; Rev. Ralph Bonacker, Bellevue Hospital, New York; Rev. George Dominick, St. Louis City Hospital, and Rev. Donald C. Beatty of the V.A. chaplain staff.

A tour of St. Louis hospitals is scheduled for Friday afternoon, September 19, immediately preceding the formal opening of the convention with a round table meeting on current hospital problems that evening. Dr. R. C. Buerki of Philadelphia and Leo M. Lyons of Chicago are coordinators for the round table discussion.

Meetings on the following day will cover nursing problems, hospital costs, personnel, the federal hospital program and the regular business session of the A.P.H.A. The annual banquet will be held at 7 p.m. Saturday, September 20, in the Hotel Jefferson.

Pepper Introduces New Maternal, Child Health Bill

WASHINGTON, D. C.—A bill to save the lives of mothers during maternity and to give children the best possible health care from birth and throughout their growing years was introduced by Senator Pepper before Congress adjourned. Sponsored by four other senators, the bill is similar to one introduced in 1945 by Senator Pepper.

Under the provisions of the bill, the federal government's grants to the states for maternal and child health services would be $20,000,000 for the first year and $30,000,000 for each of the second and third years. For services for crippled children, there would be $15,000,000 for the first year and $20,000,000 for each of the second and third years. Thereafter Congress would fix appropriation according to amounts needed.

Bureau of Standards Combines Two Divisions

WASHINGTON, D. C.—Consolidation of two divisions of the National Bureau of Standards, namely, Commercial Standards and Simplified Practice, into a single division called Commodity Standards has been announced by Dr. E. U. Condon, director of the bureau.

The new Commodity Standards Division will continue the bureau's coordinating rôle in the development of voluntary simplified practice recommendations and commercial standards with industrial and technical groups. Edwin W. Ely, former chief of the Simplified Practice Division, has been appointed as chief of the division and F. W. Reynolds, former acting chief of Commercial Standards, as assistant chief.

As the official standardizing agency of the federal government, the bureau works in close cooperation with nonfederal agencies doing similar work.

The simplified practice program, initiated in 1921, is concerned with the elimination of uneconomical variety in a particular line of manufactured products. Commercial standardization is directed toward the development of voluntary standards for manufactured products. In the case of both activities, the National Bureau of Standards acts as a centralizing agency only, on request from industrial, commercial or consumer groups. Compliance with recommendations, which are approved by the groups concerned, is entirely voluntary.

"Mercy" Priority Established for Surplus Personal Property

WASHINGTON, D. C.—A disaster surplus property program establishing for "mercy" needs a priority taking precedence over all disposals provided for under the Surplus Property Act and any other congressional act has been announced by W.A.A. The program is designed to give instant aid to victims of floods and other catastrophes occurring in the continental United States. Procedures have been perfected for application of the priority which under presidential direction and in "mercy" circumstances supersede all existing priorities.

All personal property declared surplus to W.A.A. which has not been sold, leased or definitely committed by a firm order or its equivalent is considered available under the disaster program to the extent that it can be utilized in alleviating damage, hardship and suffering resulting from an emergency which the President determines exists.

Under this program, surpluses will be shipped by the most expeditious means with shipping costs borne by Federal Works Agency or state or local government receiving the property. All transfers of "mercy" surpluses to F.W.A. will be made without reimbursement to W.A.A.

V.A. Gets Arlington Site

WASHINGTON, D. C.—The Veterans Administration has been given possession of the Nevius tract in Arlington County, Virginia, as site for the Washington area veterans' hospital. The property lies just north of Arlington Cemetery. The government appraised the value of the land at $850,827. A three months' campaign was waged to get possession of the 25 acre strip of land. Architects' plans for the 750 bed hospital have been completed and construction bids for the institution will be taken some time in the next six months.

Freezes Social Security Tax Rates

WASHINGTON, D. C.—Signed into law August 6 was the bill freezing the social security tax at 1 per cent each for employers and employes until January 1, 1950. In 1950, the rate will be increased to 1½ per cent each and in 1952 to 2 per cent.

QUESTIONS and ANSWERS

ABOUT CONTINENTALAIR ICELESS OXYGEN TENTS

QUESTION: By what method is cooling effected in the Continentalair?

ANSWER: A refrigerated evaporator containing Freon is sealed air tight in the cooling chamber. All air entering the canopy is passed over this evaporator reducing the temperature in the canopy.

QUESTION: How can the temperature be maintained constantly?

ANSWER: By means of a temperature control thermostat mounted on the Continentalair, the required temperature is set. The instant the preset temperature is reached, the thermostat disconnects the circuit, stopping the cooling process. When temperature within the canopy rises 2 degrees the thermostat automatically comes into action, connecting the circuit which will again lower temperature.

QUESTION: How is the air cleaned?

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QUESTION: How does the Continentalair control humidity?

ANSWER: A specially designed evaporator unit collects excess moisture which by condensation is deposited in a removable container.

QUESTION: What special training must a nurse or doctor have to operate a Continentalair?

ANSWER: Absolutely none; the Continentalair is simply connected to a convenient electrical outlet plug, switch is snapped on, and temperature dial set. That's all! From then on Continentalair will operate without attention for as long as it is required by the patient.

QUESTION: How well do hospitals like the Continentalair?

ANSWER: Continentalairs are in use in hospitals all over the United States. Repeat orders and installations of up to 20 units in a single hospital are substantial evidence of the Continentalairs desirability.

QUESTION: How soon can I receive a Continentalair?

ANSWER: Place your order now. The earlier your order is on our list the sooner shipment can be made, depending upon our receiving parts from our suppliers.

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Time Limits Set for Benefits Under G.I. Bill

WASHINGTON, D. C.—President Truman set July 25 as the final day that could be counted by service men and women as service during World War II in establishing eligibility for important war veterans' benefits. For purposes of education and training, as well as other benefits provided in the G.I. Bill and for vocational rehabilitation of disabled veterans under Public Law 16, the period that is considered war service thus becomes Sept. 16, 1940, through July 25, 1947.

July 25, then, becomes the date from which the following statutory time limitations will be figured:

1. G.I. bill education or training must be started within four years of that date, or date of discharge, whichever is later, and the program ends in nine years.

2. All Public Law 16 training ceases nine years from July 25.

One of every 30 veterans now in school under the G.I. Bill is studying medicine or related subjects. Of the total of 1,825,000 veterans in schools, colleges and universities as of May 1, a Veterans Administration survey showed 59,316 enrolled in all phases of medical training.

Passed in the first session of the Eightieth Congress was the bill allowing veterans to cash terminal leave pay bonds September 1. The bill that would raise the subsistence pay of veterans in college under the G.I. Bill remains unenacted.

Nationally Known M.D.'s Added to V.A. Department

WASHINGTON, D. C.—Two nationally known physicians have been added to the Department of Medicine and Surgery of the Veterans Administration, according to an announcement of July 22. They are Dr. George Marshall Lyon of Huntington, W. Va., and Dr. Louis G. Welt, clinical instructor of medicine at Yale University Medical School since July 1946 and practitioner of internal medicine at Willimantic, Conn.

Dr. Lyon will develop laboratories for the use of radioactive isotopes in the treatment of veteran patients in the 123 hospitals of the Veterans Administration. Dr. Welt will engage in research projects for the research and education service of the Veterans Administration medical deparmtent.

Would Liberalize Old Age Insurance

WASHINGTON, D. C.—On July 21 Senator Murray introduced a bill to amend Title II of the Social Security Act by extending and liberalizing the federal old age insurance program. A companion bill has been introduced in the House.

The measure is called the "National Social Insurance Act" and is intended to increase and safeguard the economic security of individuals and their families. It would expand and improve the national social insurance program, in the opinion of the senators who sponsored the bill.

Louisiana Has Pharmacists' Organ

NEW ORLEANS.—The Louisiana Society of Hospital Pharmacists recently published its first monthly bulletin for the purpose of disseminating information to hospital pharmacists about new drugs and their uses. A. P. Lauve, chief pharmacist at the Mercy Hospital, New Orleans, stated: "The bulletin will do much to maintain interest in the association, especially among those members who reside outside New Orleans and cannot attend meetings regularly."

What COMMON OBSTACLE confronts this hospital administrator?

HE KNOWS that hospital patients should be as fully at ease as possible, *mentally* as well as physically, to promote rapid recuperation.

Yet many of his convalescents are taut-nerved, mentally uncomfortable. That's because noises reverberate through the corridors and into bedrooms and wards . . . the click of visitors' heels, the hum of conversations, the clatter of service carts and dishes, and sounds from kitchens and elevators.

The remedy? Acousti-Celotex*, the best known name in sound conditioning!

In hundreds of hospitals, Acousti-Celotex sound conditioning has been found amazingly effective in creating an atmosphere of quiet. It hushes at their sources the noises inevitable to hospital operation. This protects patients from the needless disturbances and irritations that strain nerves and sap vitality. Quiet helps employees, too—it lessens fatigue and increases efficiency.

More sound conditioning has been done with Acousti-Celotex than with any other material—significant evidence of Acousti-Celotex excellence.

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Hospital.....

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City..... *State*.....

Bellevue Opens Two Rehabilitation Wards

NEW YORK.—Two new rehabilitation wards have been opened in Bellevue Hospital, New York City, through a grant of $250,000 from the Baruch Committee of Physical Medicine to New York University College of Medicine, which provides professional service to the new department. They are under the direction of Dr. Howard A. Rusk.

It is hoped that the present accommodations of 80 bed wards can be expanded eventually to accommodate 600 patients, also that rehabilitation wards will be established in other city hospitals. At the opening ceremonies on July 7, patients ranging in age from 5 to 58 demonstrated progress made in overcoming their handicaps. The wards have facilities for physical therapy, occupational therapy, vocational guidance, social service, adult education and physical retraining and recreation.

Seeks Social Security Extension

WASHINGTON, D. C.—Extension of social security benefits was again sought in the last hours of the first session of the 80th Congress through a bill introduced by Senators Wagner and Murray. The bill would extend social security coverage to some 10,000,000 now excluded, including employes of nonprofit hospitals.

COMING MEETINGS

ALBERTA HOSPITAL ASSOCIATION, Edmonton, Alta, Oct. 20-26.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Hotel Commodore, New York City, Sept. 8-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 22-25.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Jefferson, St. Louis, Sept. 20-22.

AMERICAN COLLEGE OF SURGEONS, Clinical Congress, Waldorf-Astoria Hotel, New York City, Sept. 8-12.

AMERICAN DIETETIC ASSOCIATION, Philadelphia, Oct. 13-17.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 22-25.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Hotel Del Coronado, San Diego, Calif., Oct. 3-Nov. 7.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Sept. 19-21.

AMERICAN PUBLIC HEALTH ASSOCIATION, Atlantic City, N. J., Oct. 6-10.

CANADIAN HOSPITAL COUNCIL, Winnipeg, Man., Oct. 16-18.

NATIONAL LEAGUE OF NURSING EDUCATION, Seattle, Sept. 8-11.

NEBRASKA HOSPITAL ASSEMBLY, Fontenelle Hotel, Omaha, Nov. 13-14.

1948

ASSOCIATION OF WESTERN HOSPITALS, Biltmore Hotel, Los Angeles, April 19-22.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Bellevue-Stratford Hotel, Philadelphia, April 28-30.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 6-8.

TEXAS HOSPITAL ASSOCIATION, Dallas, March 4-6.

Reopen Campaign for Negro Hospital

A campaign for $200,000 to build a new hospital for Negroes in Evanston, Ill., was resumed two months ago and is expected to be completed shortly. More than a year ago about $100,000 was raised toward the objective. Distribution now of a booklet called "Half a Hospital Isn't Enough" is a feature of the revived effort to provide the large Negro community in Evanston with adequate hospital facilities.

The booklet includes statements describing the need for such facilities by medical authorities, such as Dr. Winston H. Tucker, Evanston health commissioner, and Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, which has granted the existing community hospital its provisional approval status.

The proposed new building will accommodate 50 patients, whereas the existing hospital, occupying a remodeled residence, has a capacity of only 18 beds.

Satisfactory Service Certified

WASHINGTON, D. C.—Any navy nurse who served honorably during the war and who has been separated from the navy is entitled to a certificate of satisfactory service as well as a notice of separation from the U. S. Naval Service, or a statement of service in lieu of the notice of separation, Capt. Nellie Jane DeWitt, director of the Navy Nurse Corps, has announced. Nurses who served honorably at periods other than World War II are entitled to a statement of service.

St. Francis in Evanston to Expand

EVANSTON, ILL.—A building fund campaign for $1,375,000 is in progress for St. Francis Hospital, Evanston, Ill. The fund will be used to erect an addition to the main building and will consist of five major elements, designed to increase the hospital's bed capacity and provide additional facilities for the hospital's specialized departments. The addition will include general offices, waiting rooms, medical treatment rooms, pediatric rooms, a special eye department, ear, nose and throat department, admitting room offices, a pharmacy, staff rooms and private patient and nurses' facilities. Plans also include arrangements for a new library and museum. Special attention will be given to educational facilities.

Cerebral Palsy Exhibit Opens

NEW YORK—A plea for recognition of cerebral palsy victims was made recently when an exhibit was opened in Education Hall at the American Museum of Natural History. Opening of the exhibit was attended by hundreds of visitors including parents of afflicted children and a number of sufferers from cerebral palsy. Health Commissioner Israel Weinstein urged establishment of a cerebral palsy treatment center to be supervised by the board of education and the board of health with the cooperation of one of New York's medical schools. The exhibit featured explanations of the nature of cerebral palsy and methods used in treatment.

Will Train for General Practice

CHICAGO.—A two year internship designed specifically to train physicians for general practice and to counteract the trend toward specialization has been established at Cook County Hospital, Dr. Karl Meyer, medical superintendent, announced last month. The first group of interns appointed under the new plan includes 54 men and four women. "The new plan will be a great thing for medicine throughout the country," Dr. Meyer declared. "It is difficult now to find young doctors whose training is broad enough to qualify them as good, efficient country doctors. We'll remedy that situation."

Three Appointments to N.C.I. Are Announced

WASHINGTON, D .C.—Dr. Harry Eagle of Johns Hopkins University School of Hygiene and Public Health has been made director in charge of research in the National Cancer Institute at Bethesda, according to an announcement of Dr. Leonard Scheele, recently appointed chief of N.C.I.

Announced simultaneously was the appointment of Dr. David E. Price to be in charge of cancer research grants, and Dr. Austin V. Deibert in charge of cancer control.

Dr. Eagle has made important research contributions in immunity and serologic tests for syphilis. He is also known for his work in chemotherapy with reference to syphilis and tropical diseases including sleeping sickness.

Dr. Price was formerly in the research grants division of the National Institute of Health. Dr. Deibert was in charge of cancer control before its recent transfer to the Cancer Institute from the Bureau of States Services of the Public Health Service.

Congress has brought next year's budget of the National Cancer Institute to an all-time high of $14,000,000.

Veteran M.D.'s Going Back to Rural Practice, A.M.A. Bureau Reveals

A trend of veteran physicians away from ventures in city practices toward the opportunities offered in the more active general practice of smaller communities is discernible in reports coming to the bureau of information of the American Medical Association, according to an article by Virginia Shuler, director of the bureau.

"Many young physicians are still in the armed forces and a large proportion of resident physicians in hospitals are men who served in World War II," Miss Shuler said in a recent issue of the *Journal of the American Medical Association*. Approximately 5000 physicians have not yet decided on a permanent location, the article said.

"From studies of physician distribution, the general picture for location of physicians during the year following V-J Day shows an adequate supply of physicians in most of the states but reflects a need for a more coordinated system of medical service in many of the rural areas."

Foundation Awards Grants to Hospitals

NEW YORK.—Grants to several New York hospitals and convalescent homes have been announced by the People's Hospital Research Foundation, Inc., which has been organized to promote research in medicine, public health and allied fields.

Beneficiaries of the research grants include: New York Medical College; Flower and Fifth Avenue Hospital; New York University; Jewish Sanitarium and Hospital for Chronic Diseases; St. Rose's Home; Long Island College of Medicine; Beth Israel Hospital; Memorial Hospital; Montefiore Hospital for Chronic Diseases; Yeshiva University; Social Service Division, Department of Hospitals of the City of New York; Rosary Hill Home and Beth Abraham Home for Incurables.

Clearfield Drive Oversubscribed

CLEARFIELD, PA.—The Clearfield Hospital building fund campaign ended last month with a total of $821,048 subscribed. The figure represents a 37 per cent oversubscription of the goal of $600,000 and will permit the hospital to go further than had been hoped in its long range building program. The immediate objective had been construction of a new five floor, 85 bed wing and extensive remodeling of the present hospital plant. Seventeen members of the hospital's medical staff contributed $70,250 to the fund.

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With These Words, Dorothea Lynde Dix, speaking before Legislatures—campaigning by letters—in personal calls—carried on her one-woman crusade on behalf of the *mentally ill.*

The story of Dorothea Lynde Dix is one of the most inspiring in the annals of Medicine—all the more so because when she first started her campaign in 1838, she herself was desperately ill of tuberculosis!

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Miss Dix lived to the age of 85, and before she died, she had instigated the establishment of many hospitals throughout the United States, Europe and Asia.

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Untold thousands of people in our hospitals serve unselfishly year after year. And like Dorothea Dix, these men and women put the "claims of suffering humanity" ahead of all personal considerations.

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SPECIALISTS IN HOSPITAL TEXTILES SINCE 1891

How Thick a Wall for X-Ray Protection?

Scientists at the National Bureau of Standards are engaged in an extensive program for determining the effectiveness of concrete as a protective barrier against million volt wide-beam x-rays, according to a recent report from the bureau.

At the present time, exact wall thicknesses and most desirable types of construction necessary for maximum short wave length x-ray protection are not definitely known. One of the basic aims of the new project is to collect data from which the highest degree of protection with the lowest possible cost of installation can be calculated.

When a broad x-ray beam enters a thick concrete wall, the report explains, it is scattered and rescattered many times with the result that a considerable fraction of the beam emerges on the other side, endangering personnel. Quantitative information on the amount of this scattering is not yet available. Institutions using million volt equipment have been seriously concerned with this phenomenon and in order to assure a wide margin of safety have constructed walls of exceptional thickness.

V.A. Is Giving Aptitude Tests for Medical Career

WASHINGTON, D. C.—Veterans Administration is giving aptitude tests designed especially to measure aptitudes for medicine to veterans seeking advisement before entering medical school, according to a recent announcement. The V.A. test is not the one currently used by a number of colleges in determining qualifications of medical school candidates. Veterans who take the V.A. test will probably not be required to take another upon application for medical school.

Advisement and guidance officers have been cautioned to consider the veterans' school grades, general scholastic aptitude, interest and personality traits before recommending the test.

The tests, titled Scholastic Aptitude Tests for Medical Schools, Form I, were prepared by Moss, Hunter and Hubbard. They will be used together with other tests of medical interest, general scholastic ability and achievement in biological studies.

Pathology Laboratory to Be Established

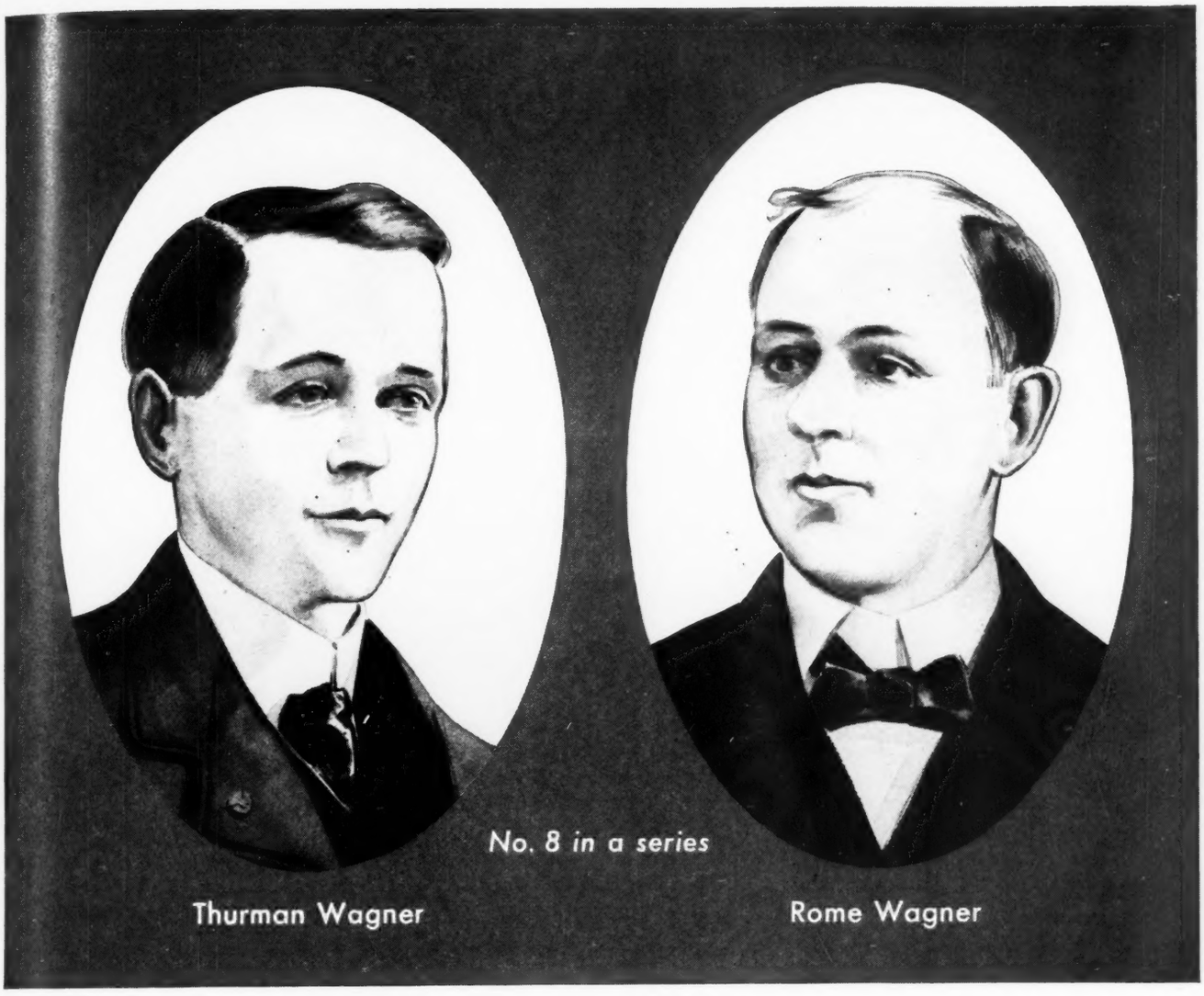
WASHINGTON, D. C.—A central laboratory for pathology will be established here in cooperation with the Army Institute of Pathology, the Veterans Administration has announced. The laboratory will provide a consultation, review and diagnostic service in pathologic tissues for V.A.'s 126 hospitals and other medical facilities.

Pathologists of the Veterans Administration will work with the army, civilian medical societies and others in maintaining a central file of pathologic anatomy and related records for reference, research, training and long-range follow-up programs. The joint laboratory will provide instruction in pathologic anatomy and histopathologic technics for V.A. pathologists and technicians; conduct research in various diseases, and cooperate with similar research programs of the Army Institute of Pathology.

The laboratory will also provide study and review material in the form of study sets, atlases and clinicopathologic conferences.

St. Louis Blue Cross Moves

ST. LOUIS.—Removal of the offices of Group Hospital Service, St. Louis Blue Cross, to new enlarged quarters at 4904 Delmar has been announced by Elmer F. Nester, executive director. Service units are located on the ground floor while other departments occupy the entire fourth floor of the building.



Suffering from acute lesions they walked the floor and sang!

THOUGH he had long trained for medicine, Rome Wagner could not seem to lose his interest in applied electricity.

He began taking out patents on his many inventions. By 1900, he had completed his mica plate static-machine. His major contribution to radiology, this apparatus increased the volume and tension of the electrical output of the static-machine.

To develop all his inventions, Rome established a manufacturing plant in Chicago. He helped his brother through medical school. And working with him, went on to develop and demonstrate new pieces of x-ray equipment.

On one such demonstration trip, both brothers received severe burns. Their acute lesions increased, because neither brother would give up his work. When their suffering became too severe, they would walk the floor and sing popular songs—making light of it.

Together, they continued their work, right up until Rome died of metastatic carcinoma of the liver in 1908. Thurman died, four years later.*

* * *

For a great many years, Ansco has been connected with the science that these men pioneered—has been experimenting and developing modern chemicals and films for the x-ray.

One of the chemicals developed by Ansco some years back, is Ansco Liquadol. A liquid developer, it's ready in an instant—acts quickly. Produces radiographs of high peak density and contrast.

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*"American Martyrs To Science Through The Roentgen Rays," by Percy Brown, M.D. Published by Charles C. Thomas, Springfield, Ill.

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Changes in Office of Nurse Education and Resources, U.S.P.H.S.

WASHINGTON, D. C.—Many of the nurse education consultants assigned to the Office of Nurse Education and Resources, formerly Division of Nurse Education, have been reassigned to other bureaus and divisions of the Public Health Service, according to Lucile Petry, chief of the division of nursing.

The cadet nurse program will be administered from the Washington office without nurse consultants in the district offices. Minnie Pohe will continue as chief and Ellwynne Vreeland and Edith Barnes will assist her.

Louise Waagen, formerly in the San Francisco district office, has been assigned to the Hospital Facilities Division. Other nurses who have been in charge of district offices will be assigned to the mental hygiene division and the hospital division. Amy Viglione of the Kansas City district office will remain in that office, although her functions have been expanded to include nursing service consultation as it relates to the hospital survey and construction program.

Chicago's Mount Sinai to Add Two Floors

CHICAGO.—A 60 bed addition to Mount Sinai Hospital is planned at an estimated cost of $350,000, Dr. Stephen Manheimer, hospital director, has announced. The addition will add a tenth and eleventh floor to the present building to provide private and semiprivate rooms and four bed wards.

"During the past four or five years the number of patients waiting for admission to Mount Sinai Hospital has ranged between 250 and 400," Dr. Manheimer explained. "The pressure for beds became terrific about two years ago when many of our physicians were separated from the army and returned to their practice. Most of the time critically ill patients were obliged to wait twenty-four hours or longer for admission. Patients requiring elective surgery are obliged to wait five or six weeks for a bed reservation."

To Reestablish Army Reserve Units

WASHINGTON, D. C.—Medical reserve corps units affiliated with hospitals are to be reestablished by the army medical department, it has been announced. Hospitals and other civilian organizations, according to an army report, will be invited to sponsor medical units which will be organized and trained in reserve status so as to be ready if needed for immediate military service.

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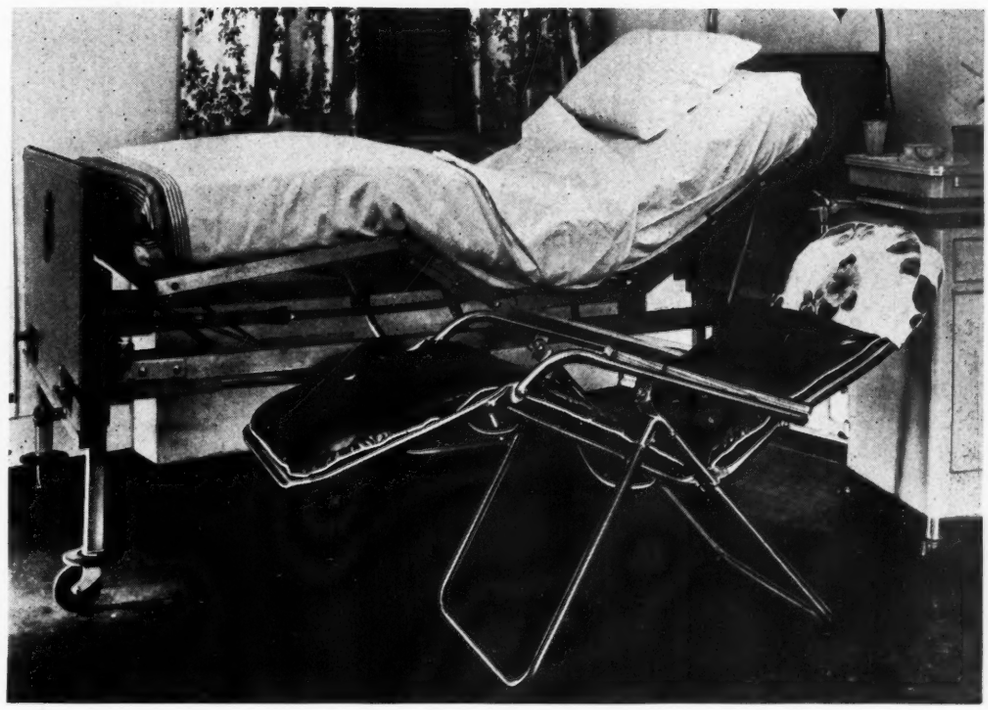

In the BarcaLoafer the patient is provided with comfort and change of position previously limited to the hospital bed adjusted through the kindly services of the nurse or orderly. In the BarcaLoafer the patient can do his own position changing almost without effort and is *very happy* to do it—a distinct morale builder.

The BarcaLoafer weighs only 41 pounds, and can be easily moved as needed. Many hospitals feel it is a MUST in every room. It is invaluable for certain cardiac cases and nerve patients that require utmost rest, and in post-operative cases where it is important to get the patient out of bed as quickly as possible.

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Calls Nurses Victims of Unsound Hospital and Medical Economics

NEW YORK.—Nurses must not be expected to assume financial responsibility for an unsound medical and hospital economic structure, Dr. Eli Ginzberg, professor of economics at Columbia University, declared at a meeting of the alumnae of the nursing education division of Teachers College at Columbia.

"Supply and demand have created a highly exploited situation which the teaching hospitals did not fail to utilize," Dr. Ginzberg said. "The student nurse was treated like a slave and the graduate nurse like a freed woman without means. Small wonder therefore that the nursing profession has been forced to devote a large part of its organization efforts to raising standards of employment.

"It is true that most voluntary hospitals are struggling to balance their books," Dr. Ginzberg continued, "but these simple truths relate to the economics of medical care which are worm eaten and crumbling. One constructive approach will be to restudy the current assignments of nurses in detail to discover how adjunct personnel can be used.

Beware of Old Aerosol Bombs, Group Warns

NEW YORK.—A charge that the War Assets Administration is distributing various types of aerosol bombs without proper protective measures was made last month by the National Association of Insecticide and Disinfectant Manufacturers.

A letter signed by H. W. Hamilton, association secretary, said: "Many of the aerosol bombs which are finding their way into various outlets are old and were manufactured in plants rushed with war production. It is more than likely therefore that a considerable proportion of the bombs themselves and the dispensing valves are faulty. This may result in danger to user."

The letter also pointed out that many of the bombs are not labeled properly for civilian use.

The association urged "reasonable inspection before sale" to ascertain that bombs are in good condition and functioning properly. Otherwise, it was recommended the bombs should be scrapped to prevent "possible serious accidents and injury to the health of users."

Florida Pharmacists Refreshed on State Law

BIRMINGHAM, ALA.—At a recent meeting of the Florida Pharmaceutical Association at Tampa, Fla., the association agreed to promote a better understanding of the Florida law, which requires competent, registered pharmacists to dispense and compound prescriptions in the drug stores and hospitals of the state. The Florida Hospital Pharmacists Association, of which Mrs. Anna D. Thiel, Jacksonville, is president, endorsed this measure wholeheartedly.

The Florida law protecting the public, both in drug stores and in hospitals, has for its main theme the requirements that "compounding or dispensing drugs, medicines or chemicals for medicinal use, or compounding or dispensing physicians' prescriptions shall be done by a competent, fully qualified and graduate pharmacist passing the Florida State Board's requirements."

Exhibits Prosthetic Devices

WASHINGTON, D. C.—Veterans Administration opened in Washington, D. C., in July an exhibit of prosthetic devices, the only one of its kind in the world, in the V.A. headquarters here. Harold Russell, World War II veteran, who lost both hands and was one of the stars of "The Best Years of Our Lives," was present the opening day and assisted in explaining the devices to visitors.

Study Control of Bacteria in Tuberculosis Wards

WASHINGTON, D. C.—An oil emulsion designed to immobilize bacteria in tuberculosis wards and hospitals is being studied in an intensive pilot test in a New England Veterans Administration hospital.

The test is a follow-up of observations made by the army and navy in experimental studies carried on during World War II. The purpose of the experiments is to reduce further the danger of hospital employes' contracting tuberculosis and transmitting it to others.

In the pilot test under progress, blankets, bed linens and floors have been treated with a highly refined mineral oil, trapping settling bacteria and preventing their recirculation by air currents and other movements within patients' rooms.

Problems to be worked out with the immobilizing oil are: The oil must not be perceptible to sight or touch or produce skin irritation through contact; treated bedclothing must not create a fire hazard; the bedclothing must be capable of laundering without special equipment or additional personnel; a relatively inexpensive method of oil treatment must be developed; the oil must not have a deteriorating effect on flooring.

ABOUT PEOPLE

(*Continued from Page* 94.)

trator of Huntington Hospital, Huntington, Long Island, N. Y. He was formerly public relations director of Grace-New Haven Community Hospital, New Haven, Conn. Miss Hutchinson, whose resignation from Huntington was reported last month, has accepted an appointment as administrator of the House of the Holy Comforter, New York City.

Dr. Lewis E. Jarrett has resigned as director of Touro Infirmary, New Orleans, it was announced recently. Dr. Jarrett was named director of Touro in April 1944 and is currently president of the Louisiana Hospital Association. He was formerly head of the Medical College of Virginia Hospital at Richmond, Va. **Joseph W. Hinsley,** assistant director, will serve as head of Touro until a permanent successor to Dr. Jarrett has been named.

Adolph Drabkin has been appointed assistant executive director of Beth Abraham Home for Incurables, Bronx, N. Y. He was formerly associated with Beth Israel and Sydenham hospitals in New York City.

J. Dewey Lutes, formerly superintendent, Yonkers General Hospital, Yonkers, N. Y., has been appointed superintendent, Norburn Hospital, Asheville, N. C.

Dr. J. Horowitz, who has been serving as administrative intern, Israel-Zion Hospital, Brooklyn, N. Y., has been appointed assistant director of that institution.

John D. Martin who has been serving as administrative intern at the Medical Center, Jersey City, N. J., has been appointed assistant superintendent, Ball Memorial Hospital, Muncie, Ind.

Ronald D. Powell who has been administrator of Bay City Samaritan Hospital, Bay City, Mich., and general manager of Jones Clinic since 1928 has resigned to accept the position of superintendent of Memorial Hospital, Colorado Springs, Colo.

Department Heads

Nona Zeda has been appointed supervisor of the social service department at Mountainside Hospital, Montclair,

N. J., succeeding **Gladys Jones** who resigned because of illness. Miss Zeda has a master's degree from the New York School of Social Work, in addition to a B.S. degree from Temple University. Before entering the field of medical social work at the Hospital for Joint Diseases and at Montefiore Hospital, New York City, Miss Zeda did social work in public welfare in Philadelphia.

Dr. Louis L. Klostermyer is the new full time director of the department of roentgenology at Mountainside Hospital, Montclair, N. J. He came from Wyoming County Community Hospital, Warsaw, N. Y., where he was first chief of medical service and then a full time radiologist.

Wilhemine Reichgert, R.N., has been appointed director of nursing at Montgomery Hospital, Norristown, Pa. She was formerly assistant director of nursing at Chester County Hospital, West Chester, Pa.

Mrs. Irma E. Henley, R.N., has been named director of nursing at Bishop Clarkson Memorial Hospital, Omaha. Mrs. Henley is the widow of **Thomas F. Henley** who was head of Clarkson until his death last December.

Frieda Roerden, R.N., has been named superintendent of nurses of Lutheran Hospital, Beatrice, Neb., succeeding **Alene Voss.**

Mabel Johnson, R.N., is the new director of Byran Memorial Hospital School of Nursing at Lincoln, Neb., succeeding **Mrs. Ruth Raschke,** who has accepted a similar position at Ancker Hospital School of Nursing, St. Paul, Minn.

Jane Hildebrandt is the new dietitian at St. Francis Hospital, Grand Island, Neb.


Mrs. Mary Hagar

Mrs. Mary Hagar has been appointed supervisor of adult physical therapy for the hospitals at Indiana University Medical Center, Indianapolis. She succeeds **Mrs. Gertrude Muench** who is leaving after serving twenty-one years in the adult physical therapy department of the Robert W. Long Hospital to accept the position of director of physical therapy students at Florida Sanitarium and Hospital, Orlando, Fla. Mrs. Hagar was employed as physical therapist at the James Whitcomb Riley Hospital for Children last October.

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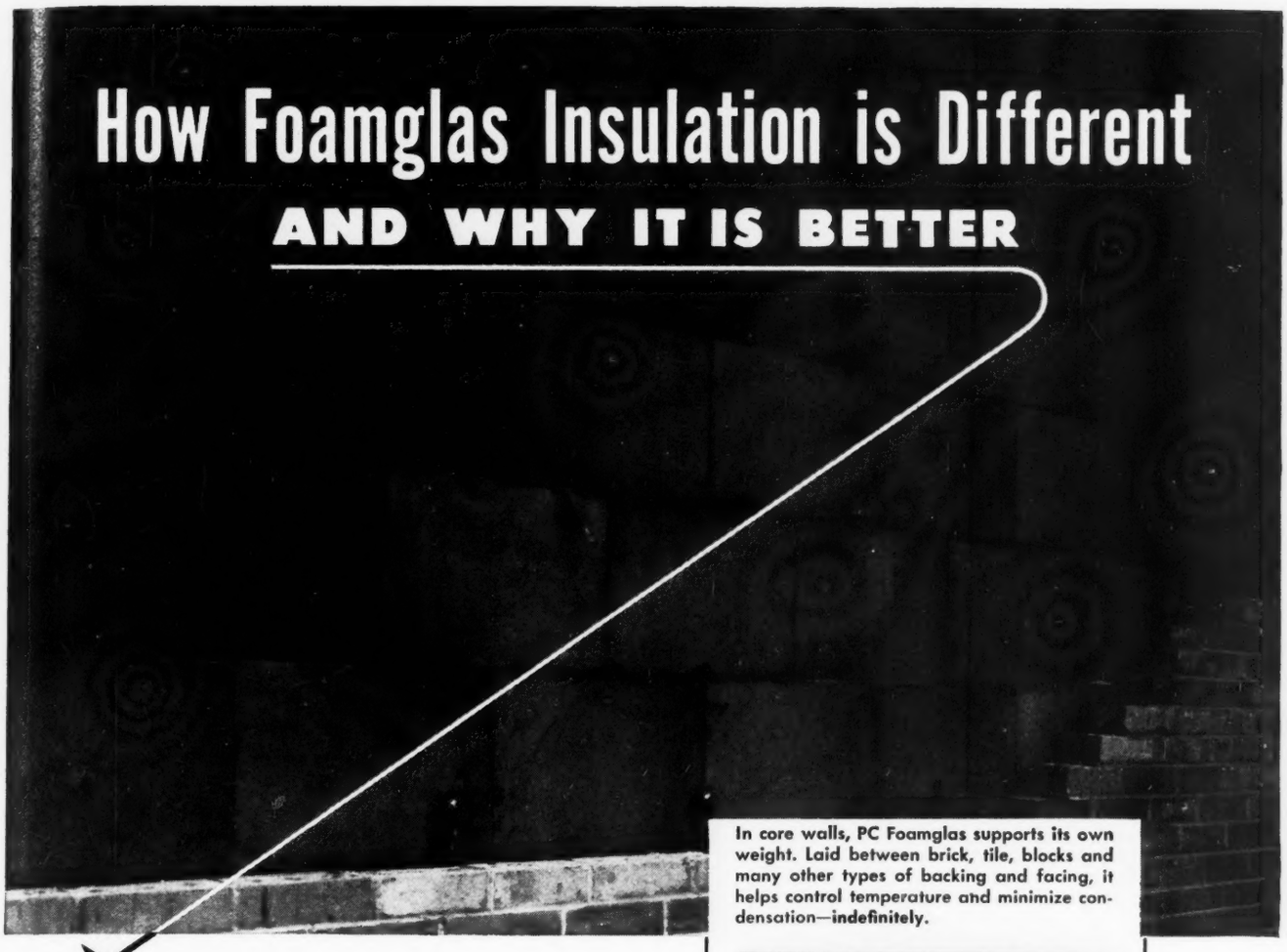
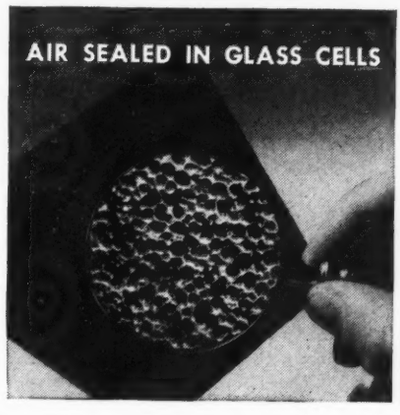


In core walls, PC Foamglas supports its own weight. Laid between brick, tile, blocks and many other types of backing and facing, it helps control temperature and minimize condensation—indefinitely.



PC Foamglas is the only material of its kind. It is not a fiber, not a wool, not a board or a batt. It is literally a foam of glass, solidified into big, light-weight blocks, each composed of millions of minute air-filled glass cells. That is how it is *different* from other insulating materials.

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Anna King now heads the social service staff of Austen Riggs Foundation, Inc., at Stockbridge, Mass., with **Edith Burtt** and **Mrs. Margaret Shriver** as her assistants.

Mrs. Robert Jolly, who has been director of nursing at Memorial Hospital, Houston, Tex., for thirty-nine years, has resigned. She has been succeeded by **Daisy Moore,** who served as Mrs. Jolly's assistant for many years.

Miscellaneous

Milton L. Daugherty of Group Hospitalization Service of Alton, Ill., has been named manager of the new Arkansas Health Plan, it has been announced jointly by the Arkansas Medical Society, the Arkansas Hospital Association and the John Marshall Insurance Company, which is underwriting the program.

Everett W. Jones, vice president of The Modern Hospital Publishing Company, and **Dr. Malcolm T. MacEachern** have been appointed honorary members of the faculty in the course for hospital directors which is being conducted by **Dr. Jorge Soto-Rivera** at Caracas, Venezuela.

Dr. Joseph W. Mountin, formerly chief of the States Relations Division, Bureau of States Services, U.S. Public Health Service, has been appointed associate chief of the Bureau of States Services with the rank of assistant surgeon general, Thomas Parran, surgeon general, announced today.

Dr. Mountin replaces **Dr. Herman E. Hilleboe,** who was recently appointed health commissioner of New York State.

While chief of the States Relations Division, Dr. Mountin helped to establish standards and procedures for hospital construction under government auspices. He played an important part in developing the organization of the Hospital Facilities Division which administers the Hospital Survey and Construction Act.

Dr. Mountin joined the Public Health Service in 1917. Assignments in Missouri from 1920 to 1927 included organization and administration of county health departments and led to his appointment as state director of county health services. Dr. Mountin took a prominent part in the 1935-37 National Health Survey, conducting the first mass study of hospital facilities in the United States. Since 1937 he has been in charge of several national divisions of the Public Health Service, including the former Division of Public Health Methods, National Institute of Health, the former Division of Domestic Quarantine and the Division of States Relations.

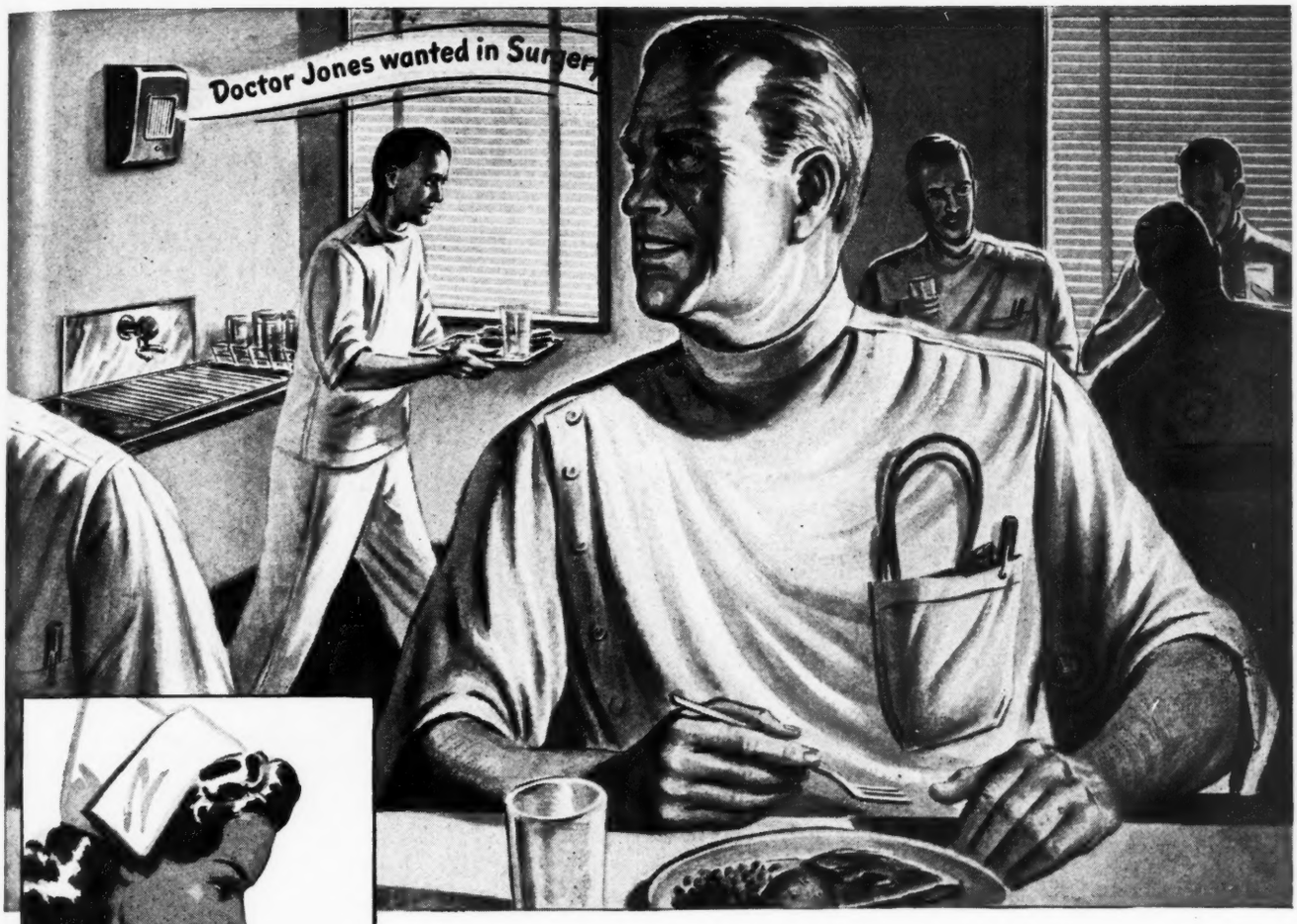
The BOOKSHELF

MEDICINE IN THE CHANGING ORDER. *New York: The Commonwealth Fund.* $2.

This volume summarizes the findings of a lay and professional committee appointed in 1944 by the New York Academy of Medicine. The *science* of medicine (broadly interpreted to include hospitalization, dentistry, nursing, pharmacy and related services) has changed with the times. The *practice and organization* of medical services must be adapted to the needs of society, the committee concludes. Our problem is not merely to increase scientific knowledge but rather to bring it into action.

The conclusions are not radical, but they are progressive. It is significant that they have been developed by a committee appointed by a nationally recognized professional society.

The fundamental methods and goals



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of medicine are stated as follows: medical science should be advanced to serve the entire population; physicians should accept leadership in better distribution; quality of service is paramount; prevention through public health service is essential; hospitals are necessary to improvement and better distribution of medical services; outpatient service should be available to paying patients; medical practice coordinated with public health activities is desirable and programs should be adapted to the needs of each community; government aid is required for experiments in coordination and for development of low cost voluntary prepayment plans.

The growing importance of "the hospital" is emphasized, with a series of 22 recommendations for increasing benefits from the public's investment in these institutions. The proposals are in accord with modern trends and include such items as: active coordination and planning through hospital councils; greater support of prepayment plans for comprehensive service; federal aid for well equipped and well placed rural hospitals; paying patients in municipal hospitals and municipal payments to voluntary institutions; development of group medical service in hospitals, coordinated with home and office practice; greater use of outpatient facilities by doctors and the public; educational programs for physicians, interns, administrators and subordinate professional workers.

This book summarizes 12 other monographs on special subjects and should be in the library of every hospital and health agency which conceives of medicine as a cooperative venture between the professions and institutions which provide the service and the general public which receives the care.

In the final paragraph the committee recognizes that it has begun, rather than completed, its study. It suggests a continuing agency which will carry its work forward.—C. Rufus Rorem.

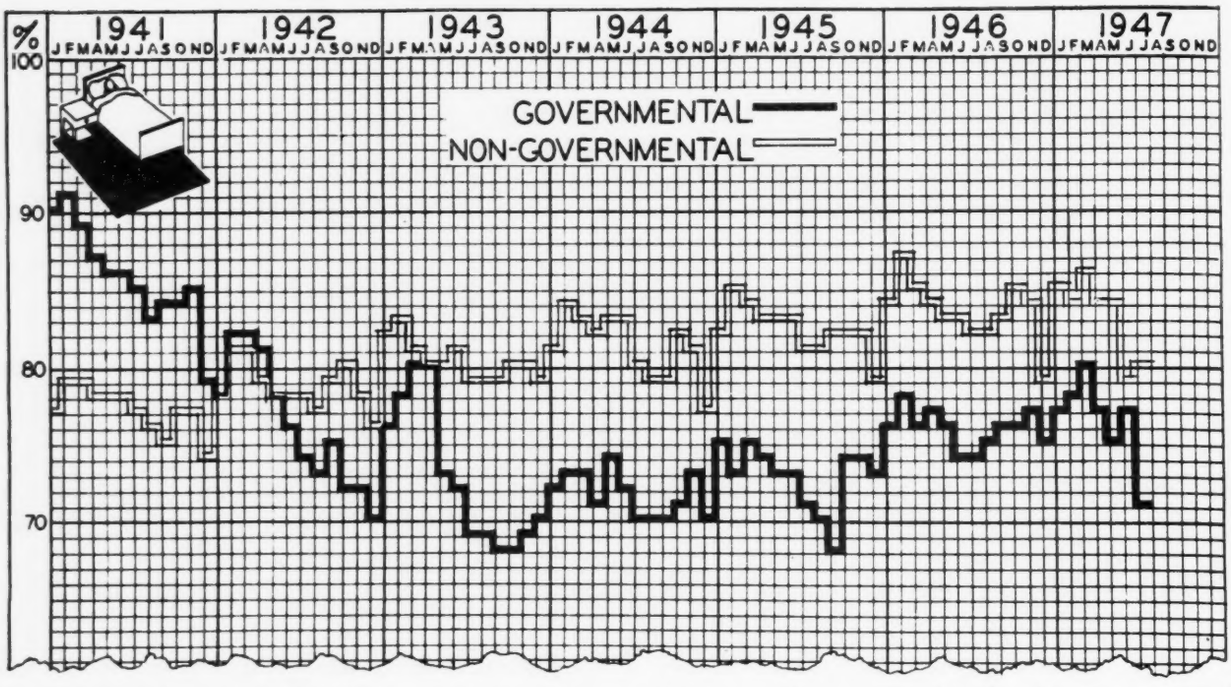
Hospital Care in the United States. *By the Commission on Hospital Care. Arthur C. Bachmeyer, M.D., Director of Study; Maurice J. Norby, Associate Director. New York: The Commonwealth Fund,* 1947. *Pp.* 631. *Cloth. Price* $4.50.

With its inspiring vision of an integrated hospital system in place of today's crazy quilt, and its view of a general hospital which would offer care for all kinds of illness, instead of just acute medical, surgical and obstetrical patients, the Commission on Hospital Care made its report on hospital care in the United States a road map of the journey ahead, as well as a record of where we have been and where we are today—or were a year ago when the report was written.

The principal recommendations of the commission were summed up at last year's national hospital convention and reported at the time in The Modern Hospital and other journals. It it too bad that so much time had to be used up before the report could be published in full, as it is now in this volume—not because the recommendations have lost any of their sharpness or wisdom in the meantime, but because so many who should study them in detail will now shrug them off as old stuff.

Here, then, is the picture of hospital care in America as it looked to the investigators who set the pattern for the state hospital studies which have since been made. The picture is not entirely a pretty one; many of its details are positively ugly, and some of it is murky and confusing. Nevertheless, the picture contains the broad shape of a real hospital system, however dimly seen today. To bring this up clearly will require all the artistry and patience that it takes for many people of different interests and views to work together effectively. The commission has drawn the outline. Now it is up to the hospital people of the United States to fill in the detail.

Voluntary Hospital Occupancy Drops



Nongovernmental hospitals reporting to the Occupancy Chart for July indicated 80.3 per cent of beds were full, slightly more the figure for the previous month but still less than the average established for the first half of the year. At 71.4 per cent of capacity, governmental hospitals reporting were less crowded than they were the month earlier at 76.7, but still up a little from a year ago.

Hospital construction for the last period totaled $51,464,065 as reported to The Modern Hospital, bringing total construction for the year to more than $250,000,000, approximately 17 per cent more than the total at this time last year. Of the total reported for the latest period, 23 projects were new hospitals costing $17,000,000 and 36 were additions to existing buildings.